JUNE, 1961

Journal of The Canadian Hospital Association

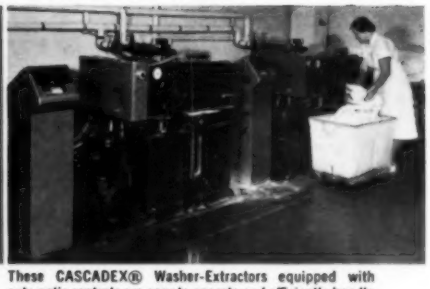
Canadian Hospital

Hospital laundry which includes a modern Canadian Press Unit featuring the all-new DYNA-PAK® Press (left). One operator beautifully finishes all laundered apparel on this high-speed unit.

These stainless steel washers with job-balanced extractor are the key to modern, efficient laundry completely planned and equipped by Canadian.

when
is a laundry machine
TOO OLD

Gas-heated drying tumbler and flatwork ironer are part of the modern, labor-saving equipment installed in this Canadian-planned and equipped hospital laundry.



These CASCADEX® Washer-Extractors equipped with automatic controls are easy to operate and efficiently handle this institution's increased volume with better quality work.

Age doesn't matter. The only accurate measure is performance! Any laundry machine is too old when it can be replaced with a new one which will . . . ■ produce more work in the same, or less, floor space . . . ■ save time and labor, use fewer operators . . . ■ turn out better quality work, cut supply and utility costs . . . ■ give trouble-free operation, eliminate costly, frustrating downtime . . . ■ return clean linens to service faster, so that less linen inventory is needed.

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CANADIAN HOSPITAL

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

Contents

June, 1961, Volume 38, No. 6

Cover Picture—Architect's Model of the Riverdale Hospital, Toronto, Ont., designed by Chapman & Hurst of Toronto.

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(1) 1960...Rebhan, A. W., & Edwards, H. E.: *Canadian Medical Association Journal* **82**:513

(2) 1959...Gaisford, W.: *British Medical Journal* **1**:230

(3) 1958...Royer, A.: *Antibiotics Annual* 1957-1958, p. 783

(4) 1958...Today's Drugs: *British Medical Journal* **2**:632

(5) 1957...Neter, E., & Hodes, H. L.: *Pediatrics* **20**:362

(6) 1956...Balkin, S. S.: *American Journal of Medicine* **21**:97

(7) 1955...Brownrigg, G. M.: *Canadian Medical Association Journal* **73**:787

(8) 1954...Pisicano, J. C.; Goldzier, S. E., III, & Larkin, V. DeP.: *Journal of Pediatrics* **44**:534

(9) 1953...Bercovitz, Z. T.: *New York State Journal of Medicine* **53**:2200

(10) 1952...Deane, G. E., *et al.*: *Pediatrics* **91**:368

(11) 1951...Lewis, R. S., & Gray, J. D.: *British Medical Journal* **2**:939

(12) 1950...Parker, R. T., *et al.*: *Journal of the American Medical Association* **143**:7

(13) 1949...Smadel, J. E.: *American Journal of Medicine* **7**:671

(14) 1948...Woodward, T. E., *et al.*: *Annals of Internal Medicine* **29**:131

(15) 1947...Ehrlich, J., *et al.*: *Science* **106**:417

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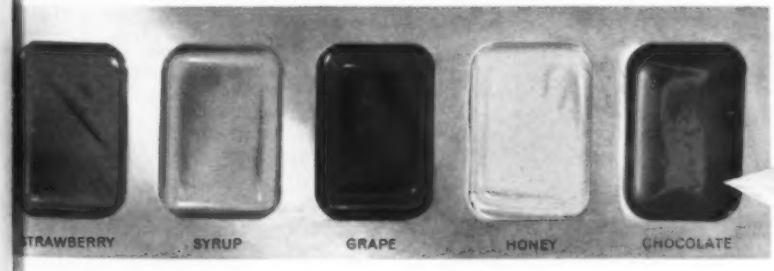
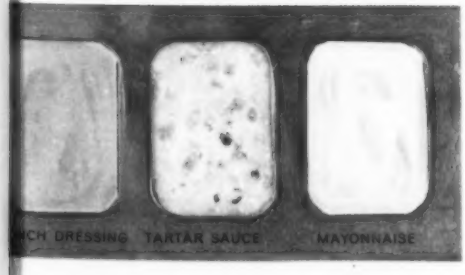
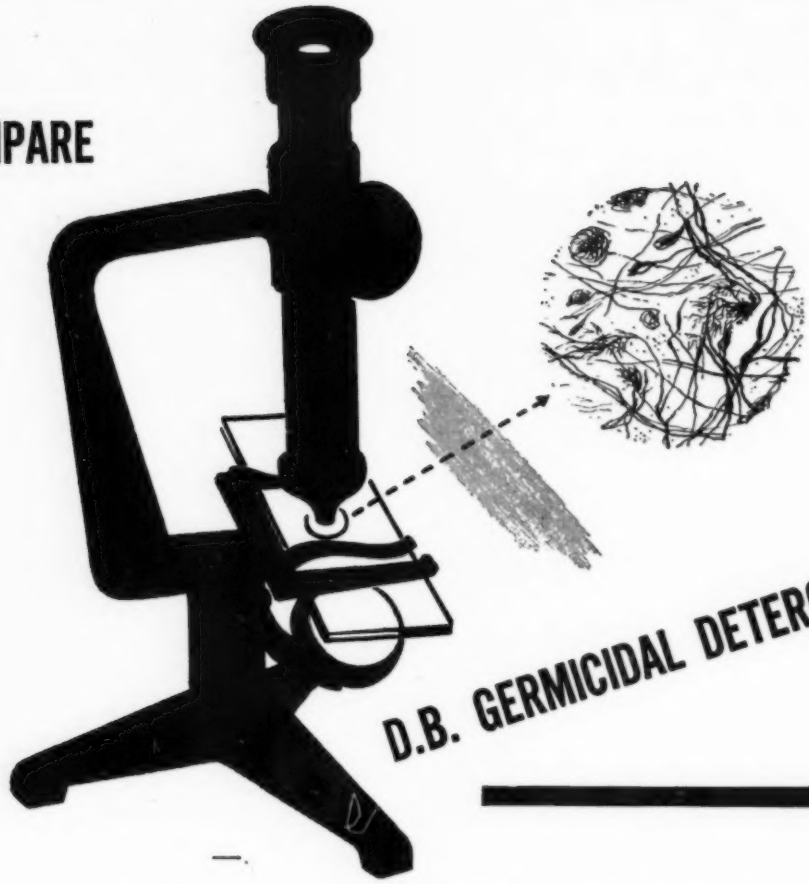




menu-planners' PC CHECK-LIST

Jams and Jellies	Apple, Mint-Flavored Apple, Grape, Currant, Strawberry, Black Raspberry, Orange Marmalade, Cranberry Sauce	For Toast, Sandwiches, Entrees
Condiments	Mustard, Ketchup	For Burgers, French Fries, Sandwiches
Dressings	French, Miracle Whip Salad Dressing, Mayonnaise, Tartar Sauce	For Salads, Fish
Toppings	Caramel, Chocolate, Strawberry	For Ice Cream Sundaes, Desserts
Syrups	Maple-Flavored Syrup; Honey	For Waffles, Pancakes, Chicken
20 PCs per tray	10 Trays to a carton (Syrup is 5 trays per ctn.)	With PCs you control costs, portions and quality

COMPARE



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It is a cold fact that during the lifetime of a building as much money is spent in keeping it clean as was spent originally to erect it.

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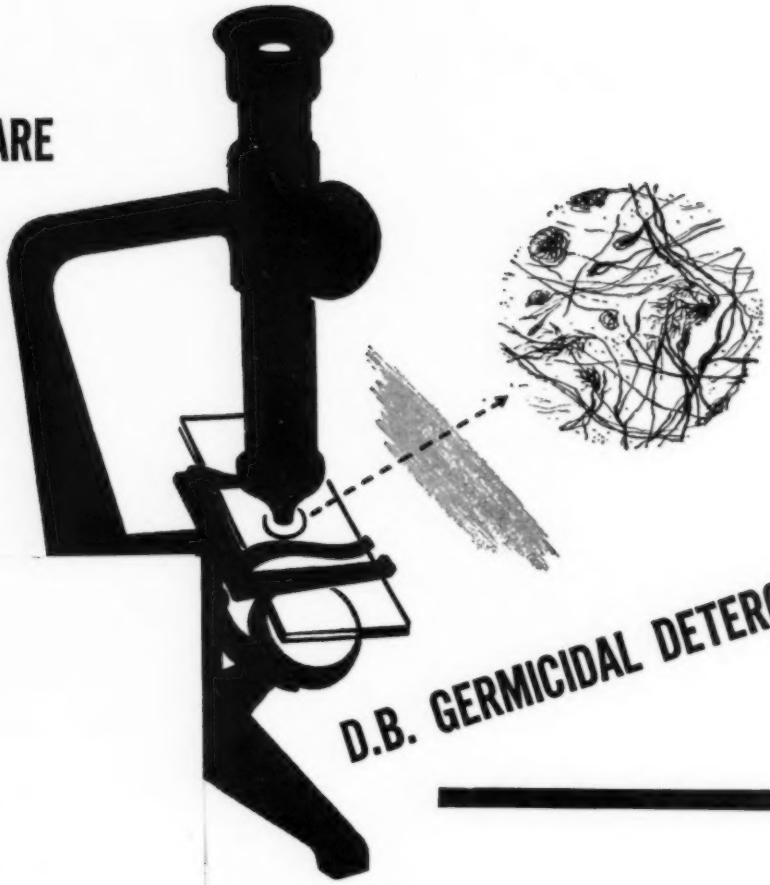

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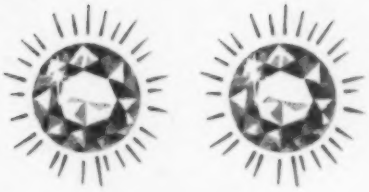

It's hard to see the difference in these two stones, but under a jeweler's glass one is easily identified as a diamond and priceless, the other a zircon, used in inexpensive jewelry. It's what's IN the stone that makes the difference.

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notes about people

At Royal Jubilee Hospital

Muriel Eileen Thompson, the new director of nursing at the Royal Jubilee Hospital, Victoria, B.C., begins her duties this month after completing the requirements for her B.Sc. degree at Teachers College, Columbia University. Saskatchewan-born and educated, she is a graduate of Winnipeg General Hospital and had previously studied at the University of Toronto, where she obtained a certificate in teaching and supervision. For the past 15 years Miss Thompson was director of nursing at the Regina General Hospital. She also served on the Saskatchewan Registered Nurses' Association Council and took a helpful part in the committee work required to make the provincial headquarters building a reality.

Director of Hospital Services Branch

Dr. William E. Noonan has been appointed director of hospital services branch at the Ontario Hospital Services Commission. Dr. Noonan joined the staff of the Commission in 1958 after being associated for over three years with the Hamilton General Hospitals. Prior to his service in Hamilton, he practised medicine in Kapuskasing, Ont.

As director of the hospital services branch, he will be responsible for the Commission's activities related to the provision of hospital services and facilities throughout the province.

Dr. R. S. Peat has been appointed assistant director (planning) for the hospital services branch succeeding Dr. Noonan. Prior to his new appointment, Dr. Peat was consultant in program development in the hospital services branch.

Promoted to Assistant Director

J. D. Snedden, C.A., formerly controller at the Hospital for Sick Children, Toronto, Ont., has been appointed assistant director. He will continue to be responsible for the financial affairs of the hospital, but in addition will assume other departmental obligations. Mr. Snedden has completed the hospital organization and management course given by the Canadian Hospital Association.

L. L. Murray has been appointed administrative assistant at the same hospital.

Administrator at Lady Minto Moves

George J. Riesz, administrator of the Lady Minto Hospital in Chapleau, Ont., has accepted a position as assistant administrator at Mount Sinai Hospital in Los Angeles, Calif. Mr. Riesz is a graduate of the University of Toronto's course in hospital administration, and the first winner of the Robert Wood Johnson Award.

Mr. Reisz is being replaced by Richard Avison, who is also a graduate of the course and has just finished his internship at the Toronto East General Hospital, Toronto, Ont.

Federal Health Educator Appointed

Michael Elliott Palko has been appointed health educator with the information services division of the Department of National Health and Welfare. His work will include evaluation of departmental health education programs, liaison with and assistance to provincial health education bureaus and general promotion of health education nationally and internationally.

Mr. Palko earned his Bachelor of Arts in Biological Sciences at the University of Saskatchewan and his Master of Public Health in Health Education at the University of California.

Prior to joining the federal government, Mr. Palko served as health education consultant with the Saskatchewan Department of Public Health and as public health educator for the Vancouver health department. Mr. Palko came to Canada in 1950 from Czechoslovakia.

Administrator Appointed for Foothills Hospital

L. Reginald Adshead, administrator of the University Hospital in Edmonton, Alta., has been appointed administrator of the new Foothills Hospital in Calgary, effective July 1.

Mr. Adshead has been on the staff of the University Hospital

(Continued on page 24)

Dr. W. E. Noonan

George J. Riesz

L. R. Adshead

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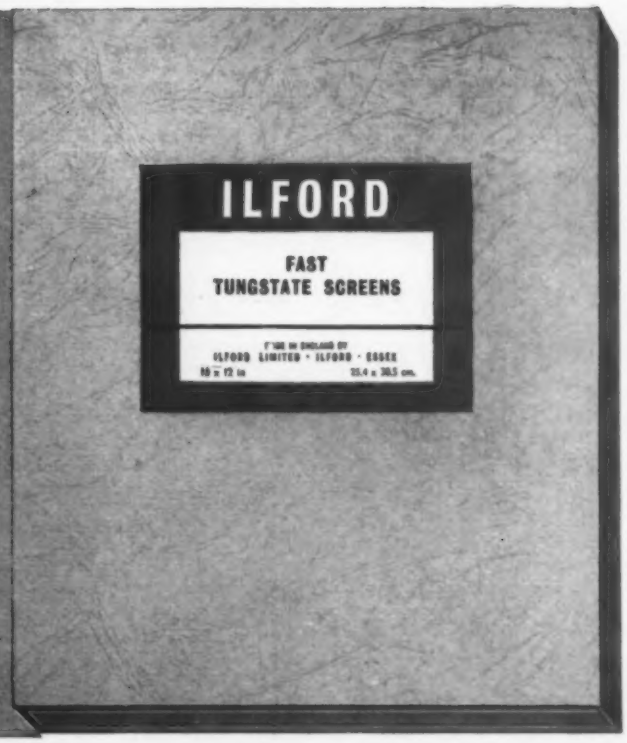

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People

(Continued from page 20)

for the past 30 years, having started as an office clerk. He was appointed business administrator in 1952 and became administrator in 1960. Mr. Adshead is vice-president of the Associated Hospitals of Alberta, and a trustee and member of the executive of the Blue Cross Plan.

Award at Quebec Meeting

A pleasant feature of the Quebec Hospital Association meeting (see page 55) was the presentation of the Robert Wood Johnson Award. Each year Johnson and Johnson Ltd. make an award to the member of the graduating class in hospital administration who shows the most promise for a continuing contribution to the field, both at the University of Toronto and at the University of Montreal. The recipient this year in Montreal was Sr. Liliane Peloquin, R.N., B.N.Ed., M.H.A., Religious Hospitallers of St. Joseph. By a special arrangement this year the president of Johnson and Johnson Ltd., Wm. C. Brayley, made the presentation to His Eminence Cardinal Léger, who in turn presented the award to Sr. Peloquin.

Rev. Sr. Liliane Peloquin.

G. F. Surphlis

G. F. "Fred" Surphlis, associated with the Ontario Hospital Association for over 16 years, died in April. Mr. Surphlis joined the Blue Cross division of the association in 1942 and for a number of years performed the tasks of assistant comptroller. He assisted greatly in the success of this voluntary non-profit service program.

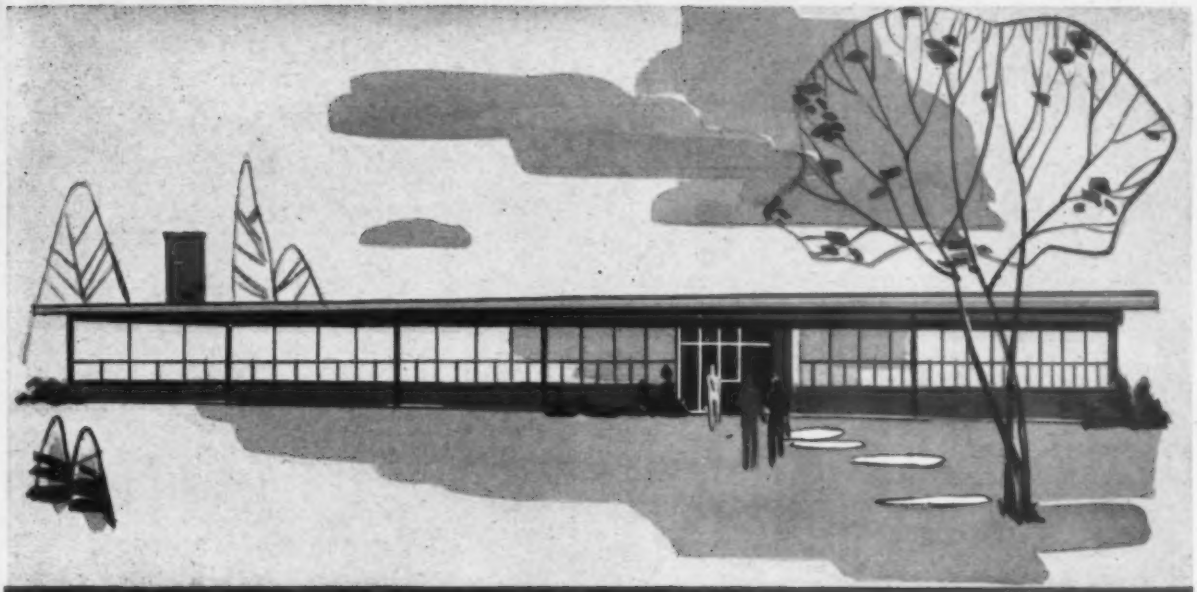
President of Blue Cross Honoured

James E. Stuart, president of the Blue Cross Association, has been selected to receive the American Hospital Association's 1961 Justin Ford Kimball Award. The award, named for the founder of the Blue Cross movement, is presented annually for outstanding encouragement given to the concept of prepaid voluntary health care plans. Mr. Stuart will receive the award at the Association's annual meeting in the fall.

Director of Nursing at Prince Rupert

The newly appointed director of nursing at the Prince Rupert General Hospital, Prince Rupert, B.C., is Beatrice Treadwell from Australia. Miss Treadwell has trained in the Johns Hopkins Hospital in Baltimore, Md., and the Michael Rees Hospital in Chicago, Ill. She has also taken

(Concluded on page 30)



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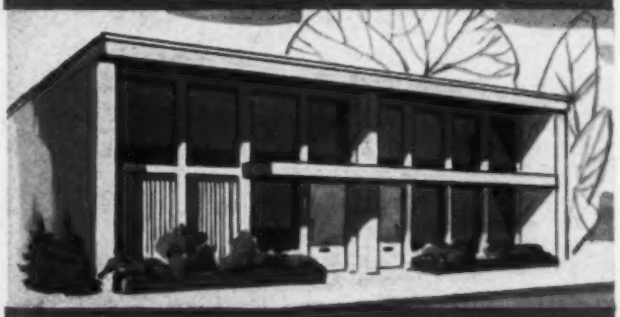

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A SUCCESSFUL PROGRAM OF EXPANSION

To maintain its leading position in the field of electromedical and X-ray equipment, and to meet the challenge of the rapidly growing science of medical electronics, X-Ray and Radium Limited has again expanded its facilities and services.

A new head office and service centre has been opened in Don Mills, Ontario, culminating an extensive three-year program of expansion, which includes new plants in Montreal and Vancouver.

X-Ray and Radium Limited engineers, specially trained in medical electronics, are available from coast to coast for installation and servicing of the most modern equipment available in the world.

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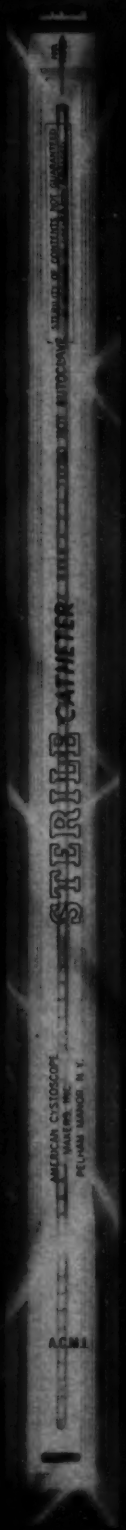
NEW A.C.M.I. STERILE DISPOSABLE URETERAL CATHETERS



For the patient: Freedom from catheter-borne infection.
For the hospital: Freedom from catheter-handling drudgery.

A.C.M.I. Sterile Packaged Ureteral Catheters, designed to be used once and then discarded, protect the patient from catheter-borne infection, and relieve nurses and hospital personnel of time-consuming washing, rinsing, sterilizing and maintenance of catheters in sterile storage. Other advantages:

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- High flow rate through large, smooth lumen
- Eye openings smoothly finished
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Supplied in half-gross cartons.

Sealed sleeve easily opened by peeling back tabs without touching catheter.

American Cystoscope Makers, Inc.
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Catalogue Nos.
2001 SP — Whistle Tip
2003 SP — Olive Tip
2005 SP — Round Tip
Sizes: 4 to 10 Fr.

INGRAM & BELL LIMITED
TORONTO
MONTREAL · ANNEX · CALGARY · VANCOUVER

(Concluded from page 24)

her diploma in nursing and hospital administration at the University of Ottawa.

Mental Health Research Fund Director Named

J. S. D. Tory, Q.C., national president of the Canadian Mental Health Association, announced that Dr. Ray F. Farquharson will be honorary director of the association's research fund.

The fund, financed by voluntary donations to mental health campaigns, was established by the association to ensure continuing research in mental health and illness.

Dr. Farquharson, professor emeritus of the University of Toronto Medical School, is also chairman of the Medical Research Council of Canada, created last November. He has been physician-in-chief at the Toronto General Hospital, and a member of the Defence Research Board. He is presently a member of the board of governors of York University.

Two Canadian scientists are at present working on studies made possible by C.M.H.A. research fund awards. They are Dr. Noël Mailloux of the University of Montreal and Dr. Patrick McGeer of the University of British Columbia.

Dr. R. F. Farquharson

New C.H.A. Directors

The 18th assembly meeting of the Canadian Hospital Association was held at the Park Plaza Hotel, Toronto, Ont., May 24-26, 1961. Some 200 delegates and visitors were in attendance. A review of the meeting will be published in the July issue of *Canadian Hospital*. The following officers were elected:

Honorary president, the Hon. J. Waldo Monteith, Ottawa; immediate past-president, S. W. Martin, Toronto, Ont.; president, Chief Judge Nelles V. Buchanan, Edmonton, Alta.; first vice-president, A. H. Westbury, Montreal, Que.; second vice-president, C. E. Barton, Regina, Sask.; treasurer, Dr. John E. Sharpe, Toronto, Ont.; directors — Chaiker Abbis, Edmundston, N.B.; Rev. H. L. Bertrand, S.J., Montreal, Que.; Dr. L. O. Bradley, Winnipeg, Man.; Mother Maille, Montreal, Que.; J. D. McClearn, Liverpool, N.S.; Rev. J. B. Nearing, Sydney Mines, N.S.; H. R. Slade, Powell River, B.C.; and C. N. Weber, Kitchener, Ont.

- A new director of nursing has been appointed at the Ross Memorial Hospital in Lindsay, Ont. She is Violet Camblin of Kingston, Ont.
- Margaret McLaren of Collingwood has been appointed director of nursing service at the Louise Marshall Hospital, Mount Forest, Ont.

Amsco's

VACAMATIC

out-produces any THREE ordinary sterilizers

Vacamatic is NOT an ordinary sterilizer. It doesn't even *look* ordinary.

This *new* Central Service Sterilizer utilizes advanced principles of sterilization to achieve its tremendous speed and positive efficiency. Vacamatic draws ultra-fast vacuums before and after each load, thus permitting instantly microbicidal pressure steam temperatures of 275°F.

In fact, so swift . . . so positive is Vacamatic that it processes a full load of linens in just *15 minutes* . . . in contrast to 70-80 minutes for ordinary sterilizers . . . *about five times faster.*

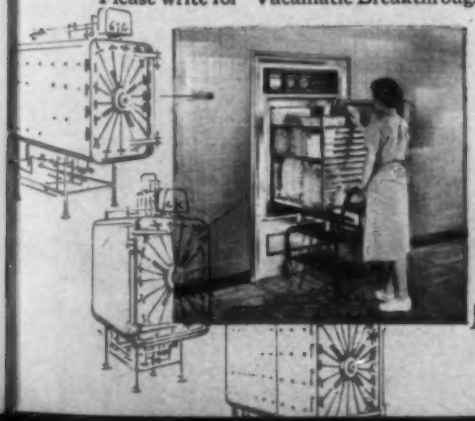
But *time* is not the only barrier Vacamatic overcomes. It provides *positive assurance* that even the most dense packs are properly sterilized (due to high prevacuum and instantly microbicidal action of pressure steam at 275° F.). Fabrics have *longer life* because of the ultra-short exposure period . . . and Vacamatic *saves vital space* in Central Service.

Smart styling of the new Vacamatic is in keeping with the most modern concepts of hospital decor. Handsome stainless steel facing plus an aqua and red control panel accent the beauty of Vacamatic.

And finally the easy operation of this advanced unit. The operator simply selects the type of load and presses the "Start" button. It's that simple . . . that *positive*. Vacamatic's "electronic brain" does all the rest.

Wouldn't a new high efficiency Vacamatic Sterilizer fit into your Central Service sterilization program?

Please write for "Vacamatic Breakthrough" Brochure SC-303.



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Wabasso double-duty sheets are the only ones in Canada woven specifically for hospital use...

WABASSO weaves these heavy-quality sheets to stand up to the exceptionally hard wear and numerous launderings demanded in hospitals. But they're tightly woven of *fine* yarns to give a smooth to the touch surface so essential to patients. *These made-in-Canada* WABASSO *sheets are also available in hospital green—through your local wholesaler or hospital supply house. The Wabasso Cotton Company Ltd.*

Halifax, Montreal, Toronto, Winnipeg, Vancouver

How *Imaginative Engineering* Pu
Taming Chicago'

John Dolio (right) in front of Powers Graph-O-Matic Control Panel with E. S. Anderson, engineer for the Illinois Psychiatric Institute.

The unusual temperature requirements specified for the new Illinois Psychiatric Institute presented an extraordinary challenge for John Dolio & Associates. This Chicago engineering firm was asked to provide an absolutely uniform temperature throughout the 11-story, T-shaped building. Because temperature variations cause extreme discomfort —even pain—to mental patients, the system had to be accurate, foolproof and automatic. Because Chicago temperatures rise or fall to extremes within hours—sometimes minutes —the system had to be capable of sensing the changing weather picture outside and automatically and simultaneously reacting inside.

The resulting design provides all the answers . . . in a Powers pneumatic control system that operates automatically 24 hours a day—every day—at a bare minimum of cost; a system that compensates instantly for sudden outdoor temperature changes; a system that can be checked and controlled by one man.

The result is a functional system of control where practical engineering principles were combined by the Dolio firm with a strong helping of ingenuity in order to whip some of the more unusual problems. For example, since chilled water was to circulate through ceiling heating-cooling panels, a safeguard against condensation was necessary. The engineers solved this problem with a series of dew point controls mounted at various locations in the ceilings. Thus, "controls on a control" prevent water temperature from falling to the point at which condensation could occur.

Phil Derrig, Chief Mechanical Engineer of the Dolio firm, inspects one of the dew point controls specially designed to prevent condensation of cold water in the ceiling heating-cooling panels.

Powers Temperature Control To Work Weather At Illinois Psychiatric Institute

Illinois Psychiatric Institute
Chicago, Ill.

Illinois Supervising Architect:
Louis H. Gerding
Architects:
Shaw, Metz & Associates, Chicago
Associate Architects and Engineers:
Fugard, Burt, Wilkinson and Orth
Consulting Engineers:
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Heating, Air Conditioning Contractor:
Gallaher and Speck, Inc., Chicago
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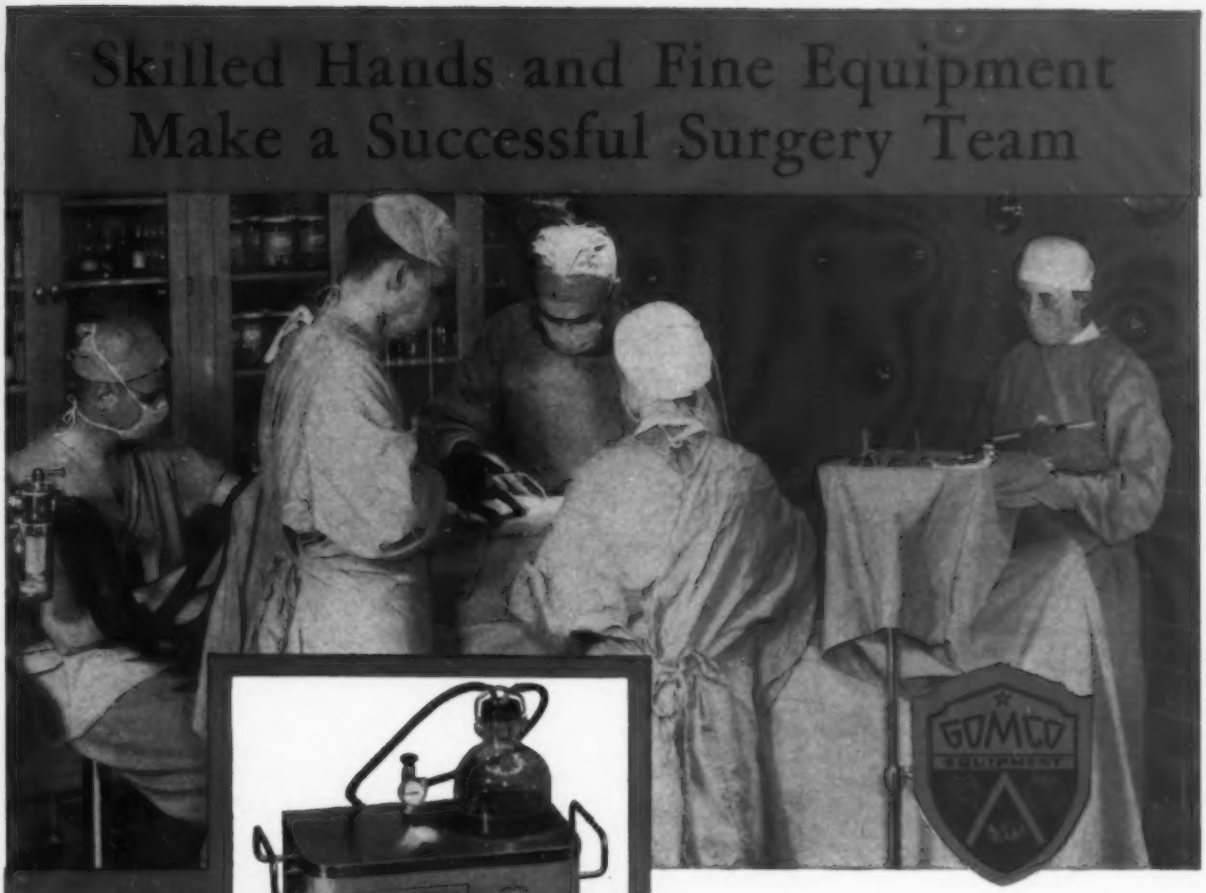

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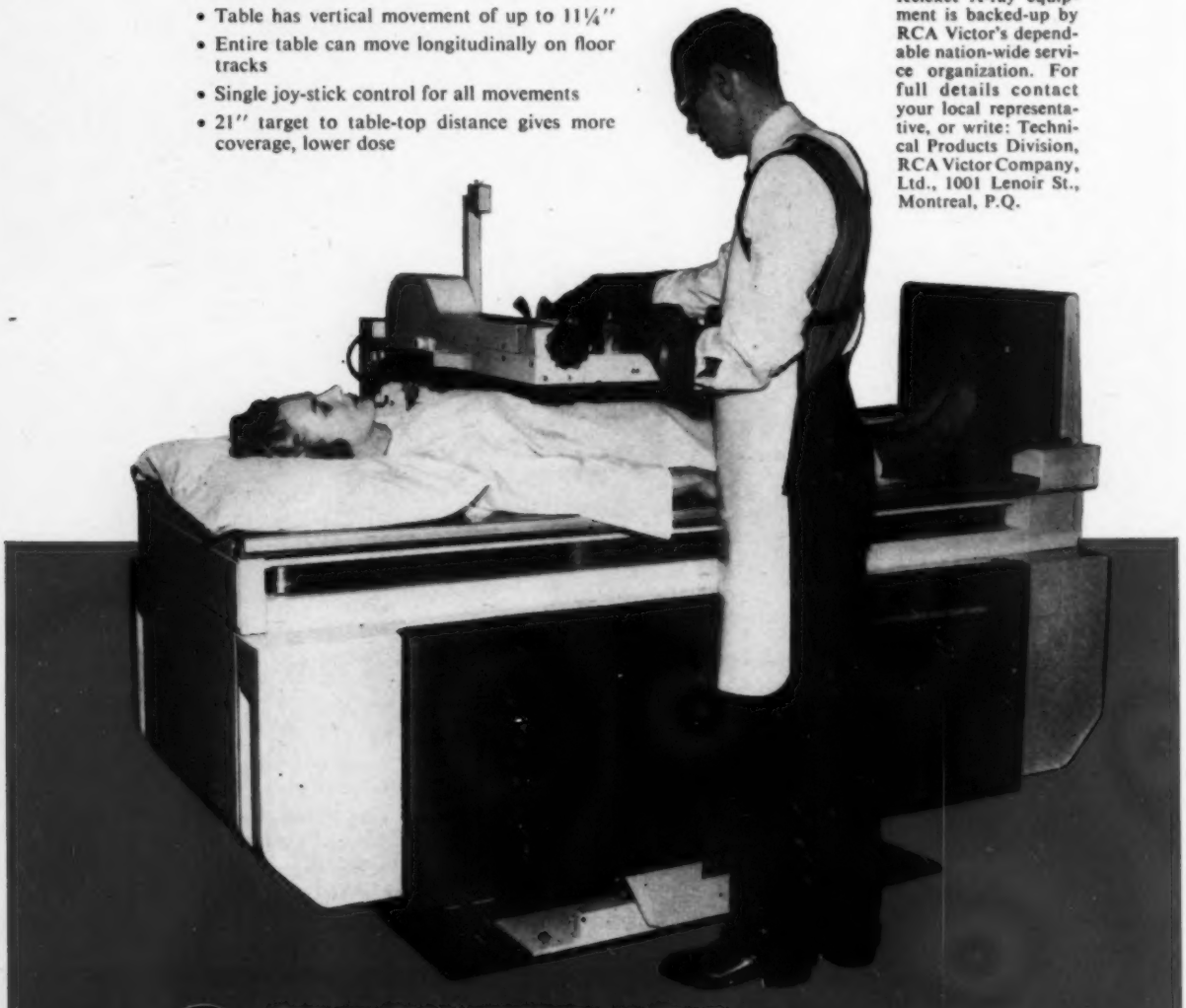

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EDITORIAL

W. Douglas Piercey, M.D.

These People Have That Extra Something

DURING the hectic early days of May, when most of the staff had a hundred and one things to do in preparation for the C.H.A. assembly meeting which was held later in the month, I was asked to write an editorial for our June issue.

Because my day-to-day work, while in the hospital field, involves the publishing and advertising divisions of our work rather than strictly hospital operation, I feel qualified to make an observation or two which may be appropriate at this time.

It was my good fortune to be on the scene when our organization came into being, and I have been constantly awed by the clear thinking, energy and devotion of so many of our top flight hospital people who created and fostered this exceptionally successful association. I shall mention just one of the many gifted men engaged in hospital work during the past generation — the late Dr. Malcolm T. MacEachern. Born in Fenelon Falls, Ont., Dr. MacEachern became an outstanding authority on every phase of hospital administration, and was well known to thousands of hospital people in Canada, the United States (where he made his headquarters) and many foreign countries. His opus *Hospital Organization and Management* is considered the bible of hospital administration.

The dozen or so top men who have served as president of our council, and later the Canadian Hospital Association, as well as the scores of directors and officers from every part of Canada who have served our interests so devotedly, deserve every honour the hospital workers of Canada can bestow upon them. Our executive directors have been few in number but each one has made a tremendous contribution to hospitals and the health field.

To one not in close touch with our various activities, a visit to our new headquarters would prove extremely enlightening. Our main floor contains the largest and most comprehensive hospital library in Canada. A full-time librarian is in charge of filing hospital articles and records of all kinds, and preparing package libraries for interested persons throughout the land. A small, but complete printing plant is situated at one end of this floor. The lessons for our various educational courses are printed here, as well as hundreds of forms and other material.

The first floor is shared by the secretarial, editorial and advertising staffs. On the second floor is located the staff for our educational courses. At present there is feverish activity here to meet the dead-line for the inauguration of our course on nursing unit administration which gets under way this fall.

In my experience with association work I know of no organization which accomplishes so much from year to year in the interests of its particular field of endeavour.

A sincere salute to all of you people who, by the time this is in print, will have converged upon Toronto to deliberate, and, I am sure, to accomplish much in the realm of promoting better health for the people of Canada.

—C. A. Edwards

The List of Hospitals now Accredited

WE would like to draw attention to the list of hospitals in Canada which were accredited as of December 31, 1960. This appears on page 68. As is pointed out in the introductory paragraphs by Dr. William Taylor, executive director of the Canadian Council on Hospital Accreditation, there are still many hospitals eligible for accreditation which do not appear on this list. This subject was discussed fully by Dr. Taylor in a progress report to the assembly of the Canadian Hospital Association on May 26. His remarks will appear in a subsequent issue of the journal.

Hospital Expansion — when is it needed?

R. J. C. McQueen
Toronto, Ont.

FIRST let us look at an example. Districts "A" and "B" are almost identical in all respects. Each is predominantly agricultural and each has a small industrial city in approximately the centre of its area. Within 25 miles of this city, in each case, there is a large metropolis with a wide range of specialized services for almost any need; in the other three directions there is nothing more for many miles than small towns and villages. There is a similar growth pattern in both cases and the population is approximately the same. The citizens of each enjoy an income above the average for the nation; there is no apparent poverty and each prides itself upon being attractive and progressive. In other words, these are desirable places in which to live, work, and raise your family. Each of these districts has only one hospital to serve its population but there the similarity ends. District "A" has a ratio of 2.4 general hospital beds per 1,000 population, with no facilities for long-stay chronically ill patients, and there are two rather inadequate nursing homes. District "B" has a ratio of 5.6 general hospital beds per 1,000 population plus 1.4 beds per 1,000 for long-stay patients in a special unit, and it has at least seven quite large and highly regarded nursing homes. Neither has a welfare institution which provides care for residents confined to bed. Simple arithmetic indicates that district "B" has three times as many hospital beds per 1,000 population as district "A", plus a much greater number of beds in nursing homes. What's more, the active treatment general hospital in district "B" has been operating at the high average occupancy of 85 to 87 per cent in the past two years, with 99 per cent at the long-stay unit; and the nursing home operators claim that business is excellent. Meanwhile, the general hospital in district "A" shows an occupancy of 80 to 84 per cent and there is always an available bed at one of the local nursing homes.

In both cases, the medical staff and the general public are urging the members of the board of trustees to add more beds; each board has been disturbed by the stories of beds in the corridors, long waiting lists, risks of cross-infection, lack of emergency facilities, staff dissatisfaction, et cetera. These are actual case histories and the decisions are facing the two boards of trustees at the moment. However, neither has the advantage of direct comparison with the other, as we have. It appears obvious that district "A" should get more beds and district "B" should not. This seems simple enough. But it won't satisfy the busy medical staff in hospital "B" and it makes the administrator an unpopular fellow with his harassed department heads and the complaining public.

Why the startling disparity in hospital facilities between two such similar communities? It is true that district "B" has a much greater number of certified medical specialists in practice than does district "A", and this always causes an increase in hospital usage. There is also a higher proportion of persons in the older age groups in district "B", and this also means a greater use of hospital beds and longer average lengths of stay. Chronically ill patients in need of hospital care have to obtain it outside of district "A", since it has no such facilities, but the number is reportedly quite limited. The average length of stay in the general hospital in district "A" is 8.3 days, whereas it is almost 12 days in district "B"; this explains much of the increased usage but no one single reason seems to explain the difference in a satisfactory manner except for the fact that district "B" has had the beds to use, whereas district "A" has not. A few years ago, district "B" opened a large new general hospital which has been the pride of the community; the citizens of the area quickly became accustomed to having hospital beds available and began to use them as if they were wonderful new inventions. The citizens of district "A", however, added in piecemeal fashion to their old building whenever the pressure became unbearable, and they have become accustomed to a waiting period before admission, except for emergency care.

Both hospitals are fully accredited and it is not for me to say whether the standard of care in one is better than the other. This

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The Author.

comparison does seem to suggest, however, that if Professor Parkinson were making a study of hospital utilization in Canada and had only these two examples, he would be forced to conclude with the law that the rate of "hospital utilization in any one area bears less relationship to the number of people served than to the number of beds available for them".

Let's see if we can establish a more practical guide for the worried hospital trustees, however; since this one is rather discouraging in its implications.

The most effective control to an unreasonable use (in the financial sense) of hospital care is to maintain a constant shortage of such facilities. This simple solution is definitely unsatisfactory to the general public, however, and the people who bear the brunt of the dissatisfaction are the medical staff who in turn relay it to the harassed admitting officer, the administrator and, probably, to members of the board of trustees.

What the board must try to determine, surely, is the degree of bed shortage which creates an endangerment to the good health of the residents served by the hospital or hospitals. They must then act in time to ward off this possibility. There are a great many communities in this country where, five years ago, the shortage of hospital beds was deemed acute by everyone concerned. Today they still consider the matter urgent. Yet the years go by and, while the population multiplies, they may not be much closer to having their additional beds and services. This is usually due to lack of a money tree in the hospital orchard. Even so, we seldom hear that unreasonable suffering or avoidable deaths have resulted from the lack of facilities which were deemed essential years ago.

What has likely happened is that the administrator and department heads, the board members and the medical staff have discovered some methods of tightening the organization and of making more effective use of the services already there, or they have looked elsewhere in the community for help. Let us look at some of these possibilities, all of which should be investigated before a hospital expansion program is justified:

Check average length of stay

It is preferable to do this by dividing the number of discharges and deaths from the hospital in a given period into the number of days in which these people were patients. Some hospitals do not keep a record of these so called "separation days" or discharge days, so that we shall have to use the next best figure, that of patient days. If it is your impression that you are operating what is usually referred to as a short-stay general hospital for the care of the acutely ill, the average length of stay should not exceed nine days per patient and should, ideally, be approximately seven days. There will be exceptions and for many good reasons. The most common exception is the large hospital which has many patients who are there for longer periods because of detailed investigation, medical teaching, special research, complicated surgery or other treatment. An average stay of 11 to 13 days is not uncommon as a result. It is obvious that the shorter the average length of stay, the greater the number of patients who can be accommodated. In fact, if a 100-bed general hospital can cut the average day from 10 to 8 days, and if it operates at 80 per cent occupancy, another 730 patients can be accommodated over the year. One of Canada's best general hospitals had an average stay of only 5.8 days for adults and children last year and of 6.1 days in 1959, and I have never heard a report that the quality of patient care was other than excellent. This is a simple way to delay an expansion program, if you can get the medical staff to cooperate.

Settle the question of long-stay patients

If you follow the guide just given and discover that the average length of stay in the hospital is over nine days, it is likely that there are a number of patients who could receive an adequate standard of care elsewhere. This could be in a special unit or hospital for long-stay patients, in a nursing home or, best yet, in their own homes. Another guide is to review the in-patient cards for adults and children on several random days at three-week intervals; if, on each review, more than 12 per cent of the patients have been in the hospital for more than 30 days, it is likely that you are caring for patients who should have other accommodation.

The active treatment hospital of over 50 beds is too expensive an operation to justify the integration of long-stay patients; and it does not provide the right atmosphere for them. In a community which needs fewer than 50 beds, there is some merit in caring for the chronically ill as part of the general service unless they could benefit from an active rehabilitation program somewhere else. If you have 50 to 300 beds, give thought to providing one or two specific nursing units for the exclusive care of these patients; equip it, staff it, and operate it for them alone. If your community requires more than two nursing units (usually 60 to 70 beds) for long-stay patients, then a special hospital should be created for them. These guide lines have many exceptions, of course, but if you have no specific arrangement for providing care for the long-stay patients of your community, you are not providing an adequate program of hospital service, and you are probably using the general hospital in a somewhat wasteful fashion.

Co-operation with other organizations

It is an expensive waste for two or more public hospitals in a medium-size community to all have deep x-ray therapy machines, cardiac surgery facilities and small specialized nursing units for urology, orthopaedics, eye surgery, et cetera. There are countless other, less dramatic and less expensive examples. Much of this is caused by the direct spirit of competition, a

natural result of our free enterprise economy; some of it results from medical staff loyalties and jealousies; some of it from religious, and perhaps racial, differences. I hope the day will come when our society is sophisticated enough to overcome individual loyalties for the good of the common cause.

How can we co-operate better? An increasing number of large cities and populous counties have organized planning councils, hospital funds or other representative bodies with a strong measure of control on capital spending for hospitals; governments have been forced to do this to an increasing degree, particularly in Canada. On the local level, do make an all-out effort for the two or more hospitals to plan together, awkward as it may be in the first cautious meetings. Encourage qualified people to establish nursing homes in your community and to maintain a high standard of care. Give thought to the establishment of a home care plan which could be operated by the hospital in co-operation with the Victorian Order of Nurses, the public health department, or on an independent basis. Such programs have received all too little attention by communities in Canada. Rather than expand your hospital, it may make better sense to support the construction of a new hospital in the district, although this decision would depend on many factors. Hospitals should complement one another, rather than compete.

Assess current use of facilities

Here note particularly the part-time use of many obstetrical services. In much of the expansion immediately following the second world war, hospital planners were told to provide for the rapid rise in the birth rate which was anticipated. We did have an increase in the birth rate, but we also had a change in the care and treatment of obstetrical patients. The average stay of seven to ten days was reduced to four to six days. Consequently many of the well-equipped maternity units are operating at 50 per cent occupancy when they should be at 65 per cent. The rest of the hospital may have beds in the corridors. If we uphold the premise of not using the obstetrical service for any other type of patient, and it happens to be on a completely separate floor or otherwise isolated from the rest of the hospital, it is difficult to make better use of these beds. On the other hand, it is often possible to separate part of the service for some other use or to exchange it with some smaller nursing unit and still have this area close enough to the nurseries and the delivery suite.

We often see communicable disease or isolation units being used at 20 per cent annual occupancy while the rest of the hospital is frantically overcrowded. Most hospitals find it safe, satisfactory and more economical, to provide isolation rooms for this purpose, and for other use, throughout the entire hospital. An overcrowded central supply department could be relieved by having most of the linen packs prepared in the laundry. An honest look at the use each area receives will often spark an idea for much better and fuller use of space and staff. "This is the way we have always done it" usually means also that "We've never analyzed it for a better use."

Look to the future

Many parts of this nation have been in the throes of an expansion which seems incredible when one looks back only a very few years. On the other hand, many other areas have shown the reverse picture. A frank analysis of the future growth of the district served by the hospital will often help to offset expensive errors. New highways sometimes make it easier and wiser to use neighbouring hospital facilities, rather than to expand your own. Changes from an agricultural to an industrial emphasis in our economy means shifts in population and in the need for hospital beds. New communities should be cautious about building extravagant facilities to serve a population which is dependent on only one industry. By catering to the whims of one doctor, many hospital boards have found themselves with unused surgical suites or with cobwebs on expensive diagnostic equipment.

Although it is certainly possible to be too cautious, every move should be a part of a master plan and should be made in the light of future needs rather than those of the moment alone. This can offset the sad picture of unused facilities or costly re-arrangements to fit altered requirements. It may be necessary to have an objective study of the community done by an outsider, but most communities are beginning to think in terms of five, ten and 20 years ahead and the local hospitals should be an integral part of that long range plan.

Admissions and discharge committee

Most hospital people are now familiar with this method of permitting the medical staff to discipline their own members into a more equitable use of the hospital beds. In essence, it requires the doctor to classify his patient as an emergency case, urgent, or elective, when he requests the hospital bed. If the patient is admitted as an emergency, it is necessary for the doctor either immediately or within 24 hours, to be prepared to defend this opinion. This he must do by the history, diagnosis and treatment as indicated on the medical record. The committee will be chosen by the medical staff, and changed from time to time. In addition to reviewing all emergency admissions, it is customary to review the situation with respect to any patients in the hospital longer than 30 days and on each subsequent 30-day period. Other criteria may be established and, in fact, it is unlikely that any two such committees will be set up or will function in exactly the same manner. In a large hospital, this function may be performed by a medical director or some other appointee of the hospital itself.

Such a committee is one of the most effective ways in which to obtain maximum use of the hospital for those patients who need it most. It is only as effective as its membership. This committee also protects the hospital from playing the rôle of arbitrator and from accusations of favouritism among members of the staff.

How Many Beds?

If we work on the assumption that all of these factors have been taken into consideration and you know that the only answer is to expand the hospital, the next big question is "By How Much Do We Expand?" This falls into two categories, that of actual bed accommodation and that of facilities. Although publicity always refers to beds, the greater need is often to relieve the badly overcrowded or antiquated diagnostic, nursing, and service departments. To determine adequacy of facilities measure the square footage of a department in relation to size of hospital and volume of work performed. These are the best guides, when compared with certain published texts, or with the figures which government and private consultants maintain—based on their experience in what seems to work best in most places.

Women's College Hospital celebrates its Golden Anniversary

Entrance to out-patient department.

The Women's College Hospital — one of the famous institutions in this country and the only women's hospital in Canada — this year celebrates its 50th anniversary. Today the hospital provides its many services with a capacity of 279 beds and 103 bassinetts, an active out-patient department and first-class ancillary services. The hospital also has a nursing school and is a teaching hospital, affiliated with the University of Toronto.

The foundation of the hospital was a six-bed clinic established by the Women's Medical College founded in 1883 to provide an opportunity for women to study medicine. After 1905 when co-education was established at the University of Toronto School of Medicine, the clinic and dispensary continued to function, providing clinical material for women students and doctors. The first in-patient was admitted in 1911 and the name was changed to Women's College Hospital and Dispensary; and in 1915 the name Dispensary was dropped.

As the founding of the hospital itself was the outcome of difficulties and obstacles which lay in the path of better medical service, so today the hospital is known for its many efforts to improve medical treatment and advance medical science. The first post-graduate training program in hospital pharmacy in Ontario has been instituted at the hospital. One of the special problems dealt with by the psychiatric unit is a study on post-partum depression — the depression suffered by a mother which may follow the birth of a baby. The hospital laboratory carried out 225,000 laboratory tests last year. Today the laboratory comprises a staff of 40 compared with only nine in 1952 and none at all — for there was no laboratory — when the hospital was opened. Only this year the hospital has opened its staff doors to male doctors. Two specialists in obstetrics and gynecology, with the qualifications fulfilling the requirements of a university teaching hospital, were appointed recently. There exists a shortage of women doctors in the above two fields as this type of practice is extremely demanding and incompatible with home and family life.

The golden anniversary was celebrated at a gala dinner at which time a presentation was made to the hospital's first nurse. But not all could enjoy the festivities to the end as from time to time a woman doctor would slip away to attend to a patient — the main reason for the creation of the hospital and its foremost duty in existing. ■

It is also necessary to project these figures ahead in order to prepare for the anticipated demand and to be aware of the trends in relation to increased or decreased use of certain areas, size of new equipment, et cetera. It is more expensive to build the service facilities than the bed space, of course. One recent project, for example, could gain permission to add only 100 beds, but practically every department was in need of renovation or relocation. The brave board went ahead with an estimate of $4 million for the program, and that comes to the rather staggering figure of $40 thousand per bed.

It is the question of additional beds which is usually the debatable one. In the past, there have been various guides for establishing the number of beds needed in any one area or hospital, including the famous bed-death ratio. To my knowledge, the perfect formula has still not been devised. The two best ones seem to be the "occupancy method" and the "population-to-bed ratio method," and I think they should both be used in every case. Each of these needs to use an economic survey of the area to determine the population predictions.

The "occupancy method" is based on ideal levels of occupancy for each service of the hospital. It works better for an expansion pro-

(Continued on page 82)

workshop on

Hospital-Patient-Family Relationships

Sidney Liswood, F.A.C.H.A.
Administrator,
Gerald P. Turner, D.H.A.
Assistant Administrator,
Martin A. Fischer, M.D.
Psychiatrist,
New Mount Sinai Hospital, Toronto.

LILY AARON was not a patient at New Mount Sinai Hospital, Toronto—in fact, she doesn't exist. But Lily Aaron served as the focal point at a workshop on hospital-patient-family relationships which was recently conducted at New Mount Sinai Hospital and which met with an enthusiastic response from those who participated. She represented the composite patient about whom the workshop revolved. Lily was the result of an intensive interview of patients by social workers to determine their reaction to the hospital before admission, on admission, while in hospital and on discharge. All department heads and their assistants studied Lily's every whim and fancy, her likes, and most of all, her dislikes about the hospital and the staff, as well as Lily's family and their relationship to Lily and to the hospital.

The idea for this all-day workshop grew out of a discussion which took place at a meeting of the Social Service Committee of the board of directors where concern was expressed for the proper understanding by hospital employees of the emotional needs of patients and their families, particularly their fears and apprehensions concerning illness and being in hospital.

Shortly thereafter, the administrator presented the concept of a program in patient, family, hospital relationship at a meeting of department heads. It was left to them to decide whether this should be pursued further and what form it should take. The department heads unanimously approved the idea of such a workshop and a committee* was formed to organize the program which would be brought back to the department heads for discussion and approval.

A number of meetings took place before the final program was prepared for submission to the department heads. The first meeting was important since it enabled the committee members to exchange ideas on what, in their opinion, was the best system for a successful program. Various suggestions came forward, such as rôle playing technique, lectures by experts in human relations, the use of case studies, films, and various combinations of these. It was decided that outside experts should not be brought in, that there should be a workshop of a day's duration, and that it should be held preferably on the department heads' day off, which would thus enable the group as a whole to attend. At subsequent meetings the program started taking shape. The committee agreed that a case study would be valuable, using the "buzz session" approach with the groups reporting on the case study. The next step was to determine what material would be used for the case study.

Questionnaire

It was recommended by the psychiatrist that the material be factual and be obtained by preparing a questionnaire to serve as a basis

S. Liswood, administrator of the hospital, discussing a point on the workshop with M. Sewell, assistant director of nursing education and Mrs. M. Brock, director of social service.

* *In addition to the authors, the committee consisted of Miss M. Sewell, R.N., B.N., assistant director of nursing education, and Mrs. M. Brock, B.A., M.S.W., director of social service.*

for interviewing patients. It was thought that, for best results, the social worker should do the interviewing. The recommendation of the committee was that no more than 40 interviews should be attempted and that they should be divided among in-patients and out-patients.

The questionnaire was prepared, reviewed, revised and finally approved. It encompassed such areas as (a) social history, (b) the period when illness was first discovered and a doctor consulted, (c) admission to hospital, (d) stay at the hospital, and (e) discharge. Within the framework of these general areas the questions attempted to gain some insight into the patient's feeling with regard to the whole experience of being in a hospital.

After approving the questionnaire, the committee reaffirmed their decision that the department of social work interview the various patients. It was hoped that through their special skills we would be able to obtain an honest appraisal of the individual's feelings with regard to the questions asked. After discussion, a sample group of 40 patients, composed of ten surgical, ten medical, five paediatric, five obstetrical and ten out-patients was selected. Patients known to the social service department were excluded from the study group, since many of their problems would slant the report. It was thought preferable that a random sampling be taken within a one month period.

Following this plan, the interviews were conducted, the questionnaires reviewed by the committee and a composite patient—Lily Aaron—was created. These 21 questions (illustration), set out in sequence, were divided into three sections of seven questions, each depicting a period of the patient's total hospital experience. The first section, questions 1 to 7, dealt with the period prior to and on entering the hospital; the second section, questions 8 to 14, included the first day and the period under acute care; and the third section, questions 15 to 21, were concerned with the period of convalescence, just prior to discharge.

It was felt that the group could be divided into three sections for the "buzz session" and that each section would review the total case study and then report on one of the three sections. The groups were selected as follows:

(a)

Comptroller and administrative assistant
Administrative resident
Chief of physical medicine and rehabilitation
Laundry manager
Director of purchasing
Central supply room supervisor
Director of nursing
Director of medical record department

(b)

Chief dietitian
Assistant supervisor of out-patient department
Chief of radiology
Accountant
Chief engineer
Chief pharmacist
Assistant medical record librarian
Assistant admitting officer

(c)

Director of volunteers
Administrative supervisor of out-patient department
Chief pathologist and director of laboratories
Credit and collections manager
Personnel director
Chief admitting officer
Chief switchboard operator

G. P. Turner, assistant administrator, and a group of department heads shown in discussion during a break in workshop activity.

The grouping of the individuals occurred after a great deal of consideration. The purpose was to have a mingling of different skills in each group to provide a variety of experiences for the discussions. It was decided that a discussion leader and a recorder should be appointed in each group to ensure proper reporting during the discussion phase of the case study. The selections made were more or less arbitrary and were not significant in that one could just as well have acted as a discussion leader or recorder as another.

Films

It was felt that all department heads and their assistants should be invited to an all-day session from 10 a.m. to 5:30 p.m. The committee felt that it would be better to have the workshop in the hospital and to use the facilities available there rather than hold it outside of the hospital setting. For a "warm-up" session in the morning appropriate films on the topic of patient-family-hospital relationships would be selected and from them a relevant discussion might arise.

From the numerous films viewed by the committee two were finally selected—*The Patient is a Person*, from the film library of the Ontario Hospital Association, and *Mr. Findley's Feelings*, distributed by the National Film Board. It was the committee's opinion that these films would serve the purpose of alerting the group to the subject. *The Patient is a Person* is fairly simple and points out what is considered good and bad in patient-family-hospital relationships. *Mr. Findley's Feelings* is not quite so obvious; but it indicates how an individual reacts to a series of events and frustrations and his method of coping with these through rationalization.

Program

It was now time to consider the program as a complete entity and to choose a suitable day for this purpose before submitting it to the department heads. A Saturday was chosen and the program prepared as follows:

Morning

10:00 a.m. Assembly
10:15 a.m. Opening remarks—administrator
10:30 a.m. Film
11:00 a.m. Coffee
11:15-12 noon Discussion of film
Leader—assistant director of nursing education

Questionnaire used in the Hospital-Patient-Family Workshop at the New Mount Sinai Hospital

History:

Interview Material:

1. (a) When and by whom were you first told you needed hospital treatment?
   (b) Were you given any information about the nature of your illness?
   (c) Were you given a diagnosis?
   (d) Were you given different diagnoses by different doctors and different advice re treatment?
2. (a) Was your illness a surprise to you?
   (b) What did you think caused it?
3. How long was it before you were told what the treatment and progress would be?
4. (a) Did the idea of being ill and in hospital make you anxious?
   (b) Did you discuss your illness and hospitalization with your family and what was their reaction?
   (c) Did you come to the hospital by yourself?
   (d) How did you get to the hospital?
5. Did the doctor give you any explanation of hospital routine?
6. (a) How long did you wait for a bed?
   (b) Who did you think was responsible for the waiting period?
   (c) Were you given any reasons for waiting?
7. Whom did you meet first when you came to the hospital?
8. (a) How did you feel about the way your reception and admission was handled?
   (b) Were your questions answered satisfactorily?
   (c) What were your emotional reactions at the time of admission?
9. Who took you to your room?
10. (a) How were the first nurses who helped you on the ward? Reassuring..... .....Co-operative.....Friendly.....
    (b) Was anybody: unkind.....rough.....rude.....disinterested.....kind.....considerate.....interested in you.....
11. (a) How many people came to see you in the first hour?
    (b) How long was it before a doctor came to examine and talk to you?
    (c) Did the doctor answer your questions?
    (d) How did you feel after this examination?
12. How did you feel about the laboratory technician and tests?
13. (a) How did you feel about the registered nurses who gave you care?
    (1) did their attitude change during your hospitalization?..... Before surgery.....After surgery.....
    (b) Did you like to keep your feelings to yourself?
    (c) Did you like the nurses and others in the hospital to show their feelings to you?
14. How did you feel about:

    Medication .....
    Sleep .....
    Pain .....
    (i) Did you have much pain?
    (ii) Was it continuous?
    Bed pans .....
    Confinement to bed .....
    Food .....
    Cleaning personnel .....
    Doctor's visits .....
    Your room-mate .....
    Nurses .....
    Smells .....
    Sounds .....
    Volunteers .....

15. (a) Are you benefiting from your hospitalization?
    (b) Who is most helpful?
    (c) Who was your favourite person while in hospital?
16. (a) How did you feel about going home?
    (b) Are you looking forward to: (i) returning home
    (ii) returning to work
    (iii) having a long or short period of convalescence
    (c) Is anybody taking an interest in your after care and rehabilitation?
17. (a) What did you feel while being in the hospital? Relief..... Tragedy..... ..... Security..... Mistake.....
    (b) Did you think life will be better..... worse..... same..... hopeless.....
18. Did you welcome or receive a visit from a clergyman?
19. Did your family visit you regularly?
20. (a) Did a member of your family accompany you to the hospital?
    (b) How long did they stay with you?
    (c) How did you feel when they left?
21. (a) While you were in the hospital, did your family receive the help and information they asked?
    (b) When you were critically ill?
    (c) When plans were being made for your discharge?
    (d) By whom?

Remarks:-

Afternoon

12:15	p.m.	Luncheon, board room
1:30-3:30	p.m.	Discussion groups
3:30-3:45	p.m.	Coffee
3:45	p.m.	Reports from recorders
4:45-5:25	p.m.	Commentary and summation by the chief of section of psychiatry
5:25-5:30	p.m.	Conclusion: chairman - assistant administrator

The program was then submitted to the department heads. It was stressed that what was desired was a refresher course for the department heads and their assistants to create an atmosphere of receptivity toward new information.

Workshop

At 10 a.m. on Saturday, November 12, 1960, all of the department heads and their assistants assembled, many with mixed feelings towards what the day would bring. The chairman introduced the administrator who traced the events leading to the workshop, stated its purpose, and emphasized that apart from those present, the ultimate beneficiary of the workshop would be the patient and his family.

The next step was the showing of the two films mentioned above. The discussion leader who was a member of the committee had very little difficulty in getting the group as a whole to voice their views about the films. Various points of view came forward such as:

a. Learn to know yourself.

b. Be honest in your relationships.

c. Realize that a patient is not normal when ill and neither is his family.

d. That the hospital was created to care for patients and that we in hospitals have entered this field in order that we may minister to the needs of the sick.

e. We must guard against permitting frustrations, sometimes caused between inter-personal relationships, to result in "taking it out on the patient".

f. Every member of the hospital through inter-personal and intra-departmental relationships plays an important part in setting the climate for good patient care.

g. With a little bit of thoughtfulness and effort a patient and his family can be brought into a strange environment with a feeling of warmth and understanding which makes all the difference in their stay in the hospital.

h. We spend a great deal of time and money on creating good public

relations, but a patient who leaves the hospital as a booster is the best public relations the hospital could possibly have.

Actually, the group was so engrossed in discussion that the period which was to end at 12 a.m. carried on for an additional half hour.

Case Study

The afternoon session was devoted to the case study. Each member was given a copy of the case study assigned to his group and introduced to the discussion leaders and recorders. The discussion leaders had received a copy prior to the workshop in order to familiarize themselves with it and permit them to act intelligently as discussion leaders. The three groups were each assigned to separate rooms and it was suggested that they study the whole case first and then concentrate on the specific section which they would report on in the discussion period.

They were given two hours for their "buzz session" and the members of the committee acted as floaters to stimulate, if necessary, discussion. The floaters after going into the various sections found that the groups were very busily engaged in discussion and required no stimulation whatsoever. In fact, it was found that the "buzz sessions" actually ran over the time limit assigned—which indicated the enthusiasm of all.

Discussion and Summation

All members of the groups met together. The group leaders took turns in presenting their deliberations and highlights of their excellent discussions, in well formulated summaries. Many interesting points were raised: The patient's need for information about his illness. The hospital, the staff members who have contact with him, and their functions, were stressed. What are the attitudes, beliefs and emotional reactions on the part of the staff which contribute most to the patient's and his family's sense of security during his hospitalization? The behaviour of all hospital personnel from the admitting office to the ward is considered important. What makes for the best and most realistic communications between patients, their relatives and staff? Who gives patients information, who decides when to give it and how much?

It was recognized that anxiety is a universal component of any acute illness, as well as in reaction to chronic disease and during convalescence. In the face of the threat that illness represents to a patient's security, patients differ in their tendency toward anxiety, their capacity to deal with new excitations and their ability to maintain a homeostatic equilibrium. The group was encouraged to look at anxiety as a normal emotional experience calling for the typical psychological reactions or defences in sick people. There is of course also anxiety as a symptom of neurotic conditions which may be greatly increased as a result of illness. The more acute or sudden the illness, the greater the anxiety—at times leading to panic and terror. This leads to an interesting process of behaviour. The patient's interests, which encompass his family, friends, work, problems in his community or the world, are withdrawn and turned back to his personality. He becomes more dependent and requires more help from his environment. When sick we all regress to an earlier form of adjustment familiar during childhood. The significance of our parents during childhood is thus matched by the importance of the doctor, nurse, husband, wife and hospital personnel. Consciously or unconsciously they are seen by the patient as substitute parents. Emotional dependence is the common denominator of patient and child. Both are anxious, both need support from without, to help them through the period of danger. This identification of doctors, nurses and other staff members with parents leads to an over-valuation of them. Unconsciously, the patient assigns to them powers of omnipotence and omniscience to do good or evil. Based on their different personality make-ups, different patients experience illness in various ways. They may range from total dependency reactions to a denial of their sickness or even rebellion.

All patients have an increased need for support, protection, attention, care and understanding which they expect from the hospital staff. These requirements are not so much directly proportional to the severity of the illness, but to the emotional need of the individual patient. This is often not recognized by the non-professional staff, and at times missed by nurses, doctors, social workers, and others.

The emphasis of all group leaders was that we are not only dealing with an illness, *e.g.* a broken leg, an ulcer, et cetera, but also with the person who is sick. This insight points to the need to individualize our treatment and contact with each patient, in the belief that what is good for one may be bad for another. One must be alert not to leave the patient in an emotionally dependent state beyond the existing needs. This is a difficult question to decide. The gradual weaning back from dependency will enhance the return to a normal, realistic life, and reduce the period of invalidism. Yet one must not be impatient and push too fast, since this increases anxiety and promotes further regression. However, to continue to accept the patient's dependency needs uncritically, beyond the time needed, is equally conducive to further regression.

It was clearly seen that the person outside of the hospital is not the same as the patient inside the hospital. Understanding, kindness and a non-judgmental approach expressed by the demeanour, the manner, the response, and the honesty on the part of the hospital staff will make the patient's hospitalization a constructive experience. There will be trust and gratitude in abundance. He will readily accept the fact that every member of the hospital team wants to make him well. This positive attitude towards the hospital and treatment will reflect in the community's attitude towards the hospital as a health-giving centre and a true place of hospitality.

The creation of an optimal therapeutic climate for the patient was seen by all as the ultimate goal. This demands a realistic understanding of and respect for the person who has an illness. No matter what psychological pattern the patient's reaction to his illness takes, even his becoming "the uncooperative patient", there must be no room for retaliation. An understanding and sympathetic approach is the one to aim at as the ideal one at all times.

There is also a greater awareness of the importance of the repercussions in a family when one of its members becomes ill. This must reflect in a new attitude regarding visiting relatives. The same sensitive, kind, honest and co-operative approach must be offered them. They must not be left to feel that they are "outsiders", whose visits interfere with the work on the busy wards of the hospital. The assistance offered by social workers to both patients and relatives is invaluable.

Many questions relating to the

(concluded on page 119)

thoughts from a small town

Getting a Community to Work For You

George J. Riesz,
Chapleau, Ont.

MANY administrators only think of informing the public and gaining goodwill when a financial campaign makes such a program an absolute necessity. A great deal of other business and, probably, a good dose of laziness may explain the inertia — but will not excuse it. Recent articles, emphasizing the importance of planned, continuous public relations have implied the need for hard work, and most likely frightened many smaller hospitals into further inertia. I shall not thunder stern reproaches at you, gentle but sleepy reader: I suggest, instead, that you let the community work for you.

The objectives of a public relations program are well known and were well described in the 15 "Specific Benefits to be Expected" by the Committee on Public Education of the American Hospital Association. In somewhat oversimplified terms we may say that:

(a) the public, to have confidence in the hospital (essential to speedier recovery and normal occupancy), *must* know something about the personnel and the physical facilities;

(b) the financial situation must be made public in understandable form if you expect the community to improve it; and

(c) the community is *entitled* to information from its own public hospitals.

The author was administrator, Lady Minto Hospital, Chapleau, Ont. As of this month he assumes a new position. *See page 20.*

What to do

Three convenient groups — the satisfied patients, happy employees and interested visitors — are always available to spread news, good and bad. Catching them, getting their attention, and starting a flow of information are not very difficult in a small community. We want lots of people to visit the hospital to see the facilities; we want the people to meet the staff in and out of the hospital; and we want many fund-raising activities, preferably with the participation of many enthusiastic and well-informed citizens. Some actual examples of activities in our small town between national hospital days in 1959 and 1960 may help:

1. On hospital open house our staff volunteered to arrange a nursing cap exhibit; the Women's Auxiliary arranged for a tea-party honouring senior citizens who helped the hospital in the past; and tea was served in the residence (satisfying some curiosity). An "historical exhibit" of ancient minutes and annual reports proved popular with the senior citizens who busily searched for their own names.

2. Our Women's Auxiliary, the major link between hospital and community, was cut in two. One branch meets in the afternoon to discuss plans for projects in an atmosphere resembling a debating society; the other branch prefers evening meetings (when the members' children have their fathers at home), where plans are decided upon through informal chats while the members embroider baby gowns, sew markings on linen, et cetera. Both groups enjoy themselves, membership has increased, and attendance improved. Employees, though they have no vote, are encouraged to join either branch, with key personnel attending and informing both groups.

3. Church groups, fraternal organizations and clubs with "shut-in" visiting service have always come frequently. With little effort we can identify their visitors and, while they are here, show them some new equipment (that may need to be paid for), point out some strengths as well as some weaknesses, or just chat with them over a cup of "good hospital coffee".

4. Similar groups, such as the church choirs and various musical bands, offered to entertain patients on most holidays. Results: as above.

5. Thanks to excellent relations with the newspapers and with our local television station, we are receiving very important help from this crucial quarter. Good examples: (a) television interviews of newly "imported" hospital personnel; (b) television talk on the hospital insurance plan (and what it does *not* cover); and (c) editorials describing accomplishments as well as needs. There were 40 articles about the hospital in the major newspaper within the past year.

6. The local horticultural society undertook to landscape our front lawn and the girls in residence volunteered to look after gardening

(Continued on page 96)

Rapport du président

de l'Association des Hôpitaux du Québec pour l'exercice 1960-1961

Paul Bourgeois,
M.D., F.R.C.S.(C)
Montréal, Que.

LA QUESTION première à l'ordre du jour a été naturellement l'assurance-hospitalisation. Le mémoire devant être soumis aux autorités gouvernementales a exigé une somme de travail considérable. Pour mener à bonne fin ce mémoire, votre conseil d'administration avait organisé un comité présidé par monsieur A. H. Westbury et assisté de monsieur Albert Nantel, président conjoint; des membres du comité de comptabilité de l'association, composé de la Révérende Mère Dorais, de monsieur Gérard Brais et de monsieur Paul Shannon.

Au cours de nombreuses séances, ces collaborateurs dévoués ont préparé un document basé sur dix principes fondamentaux visant à la sauvegarde de la qualité des soins aux malades et de l'autonomie des hôpitaux volontaires.

D'un autre côté, quelques-uns de ces membres, en particulier monsieur Gérard Brais, contrôleur de l'Hôpital Notre-Dame, et votre président ont travaillé en collaboration avec le comité provisoire de la Conférence Catholique des Hôpitaux du Québec pour préparer également un mémoire respectant les mêmes principes.

De cette collaboration est née une union de pensées et de représentation; ce qui explique qu'à différentes reprises, l'exécutif de l'Association des Hôpitaux du Québec et le comité provisoire de la Conférence Catholique du Québec se sont rencontrés.

Le 22 juin dernier, une délégation conjointe de nos deux organismes rencontrait à Québec l'Honorable Jean Lesage, Premier Ministre de la Province, pour discuter avec lui des principes énoncés dans nos mémoires respectifs. La Révérende Mère Maillé et votre président se sont faits les porte-parole de leur associations pour défendre leur point de vue commun.

Vous avez été mis au courant par la suite des promesses qui nous ont été faites. Plusieurs n'ont pas encore été mises à l'exécution notamment, la création de deux comités, l'un pour étudier et trouver la solution du problème des dettes des hôpitaux, l'autre pour établir les normes hospitalières.

Le 31 août dernier, cette même délégation rencontrait l'Honorable Ministre de la Santé pour discuter de nouveau le mémoire présenté antérieurement.

Lors de la dernière session d'automne du parlement provincial, le docteur Gilbert Turner, en mon absence, dirigeait une délégation de notre association à Québec pour rencontrer de nouveau le Ministre de la Santé et lui demander de présenter certaines considérations bien importantes, lors de la discussion en chambre de la loi de l'assurance-hospitalisation.

Toutes nos activités au cours du deuxième exercice ont nécessité quatorze réunions du comité exécutif, neuf réunions plénières du conseil d'administration et une assemblée spéciale de tous les hôpitaux - membres convoquées pour étudier la réponse du Premier Ministre et du Ministre de la Santé à nos demandes.

Dans toute cette question de l'assurance-hospitalisation, l'Association des Hôpitaux du Québec a fait preuve d'une activité débor-

L'Honorable Jean Lesage avec le docteur Paul Bourgeois, président honoraire maintenant de l'Association des Hôpitaux du Québec.

dante depuis la deuxième assemblée générale annuelle.

Les questions les plus diverses portant sur l'administration et l'organisation de nos hôpitaux ont été étudiées. Des entretiens nombreux ont eu lieu avec le directeur général du service de l'assurance - hospitalisation afin d'obtenir des explications complémentaires aux directives que nous avons reçues bien souvent en retard. Nous avons fait tout en notre possible pour établir des relations franches avec le gouvernement et lui demander de nous aviser de ses décisions avant que la nouvelle nous parvienne par les journaux ou la radio.

Je n'ai pas à vous énumérer tous les points importants qui ont été étudiés. Je souligne cependant, la nécessité devant laquelle s'est trouvé votre exécutif de confier à des comités, l'étude de certains problèmes particuliers. Je vous énumère les comités créés au cours de l'année 1960-61: (1) secrets professionels; (2) comité des services dentaires; (3) comité Croix-Bleue; et (4) comité des hôpitaux privés.

Tous ces comités ont soumis à votre exécutif des rapports soigneusement préparés, qui nous permettent d'envisager à brève échéance, des suggestions intéressantes.

Education

Pour faire suite aux demandes de plusieurs de nos hôpitaux-membres, l'association a organisé plusieurs colloques afin d'étudier des matières que vous me permettrez de vous énumérer: direction du personnel, hôpital et médecin, nursing, diététique, comptabilité et budget, entretien ménager, lingerie et buanderie, achats et magasins.

Tous ces colloques ont été organisés grâce à la collaboration de l'Université de Montréal, de l'Hôpital Notre-Dame et de l'Hôpital Sainte-Justine. Ceux qui d'entre-vous ont assisté à ces colloques ont pu se rendre compte de l'excellence des conférenciers et des démonstrateurs. Le directeur général de l'association, le docteur Gérald LaSalle, et ses collaborateurs au secrétariat ont accompli une oeuvre de géant.

Les participants (504) nous ont adressé leurs remerciements les plus sincères et plusieurs d'entre-eux nous ont demandé de répéter les mêmes instituts pour qu'à tour de rôle, les membres de leur personnel puissent y assister. Nous n'avons jamais hésité à inviter comme conférencier, les personnalités les plus fort estimées du domaine. Tous nos instituts ont été bilingues; tous et chacun se sont exprimés dans leur langue propre.

Relations Extérieures

Le président de votre association a prononcé à certains moments des causeries devant les clubs de service de la cité et des environs. J'ai exposé, au meilleur de ma connaissance et en toute honnêteté, les articles de la loi qui concernent l'assurance-hospitalisation et j'ai laissé entrevoir les répercussions sur les hôpitaux volontaires.

Le docteur Jules Gilbert, directeur du service de l'assurance-hospitalisation, a participé à un forum tenu au bénéfice des étudiants en médecine à l'Université de Montréal.

J'ai pris sur moi de manifester au Premier Ministre et au Ministre de la Santé l'esprit de collaboration qui anime notre association.

Il serait superflu de mentionner les nombreuses entrevues que votre président a accordées aux délégations qui représentent des organismes ancillaires dans le domaine de la santé.

Initiatives

Comme vous pouvez vous en rendre compte, le travail de votre comité exécutif devient de plus en plus onéreux et exige des déplacements pour toutes sortes de fonctions indépendamment du travail que nous accomplissons chaque jour dans nos hôpitaux respectifs.

C'est pourquoi, nous avons cru sage et nécessaire d'augmenter la contribution annuelle pour nous permettre d'améliorer nos communications. Nous avons acheté de l'équipement pour contribuer à augmenter la production du secrétariat. Le bulletin de nouvelles que nous recevons régulièrement à tous les mois, en est le résultat le plus tangible.

Comme je vous l'ai mentionné, le bilinguisme de nos instituts a nécessité la location d'équipement pour l'interprétation simultanée. Il y a quelques mois, le comité exécutif autorisait le directeur général à dépenser un montant d'environ $500 pour acheter les matériaux nécessaires pour notre propre système de transcription simultanée. Grace à l'ingéniosité et au travail de monsieur Walther, chef du secrétariat général de l'association, nous utilisons notre propre équipement et ainsi nous réalisons même une économie appréciable.

Comme par le passé, les membres du comité du programme et du comité des exhibits n'ont rien négligé pour faire de ce 3ième congrès-exposition un des événements les plus importants de l'année 1961 parmi les hôpitaux du Québec.

Nous avons crû nécessaire de nommer comme notre aviseur légal, le monsieur Marcel Piché, ancien président de notre association. Son expérience, son prestige et sa réputation nous seront d'une aide précieuse.

Nous pouvons être fiers de l'oeuvre accomplie depuis la dernière assemblée annuelle et nous avons tout lieu de croire que notre association continue, forte, puissante, et unie vers l'idéal qu'elle s'est fixé comme but et que je vous rappelais l'an dernier: grouper dans Québec et pour Québec, tous les hôpitaux sous la devise de l'unité.

La franche collaboration que nous apportons au comité provisoire de la Conférence Catholique des Hôpitaux du Québec, en est l'example le plus parfait et c'indique le progrès réalisé dans l'accomplissement de la tâche que nous nous étions imposée.

Comme mon terme d'office prend fin, je remettrai au futur président, une succession des plus prometteuse.

Pendant deux ans comme président de votre association, j'ai fait tout en mon possible pour mériter la confiance que vous m'aviez témoignée. Je ne vous cache pas qu'il reste encore beaucoup à faire pour demeurer l'association la plus importante dans la défense des intérêts des hôpitaux.

Les soucis et les responsabilités qui sont devenus les miens on été fortement compensés par l'esprit de camaraderie manifestée entre vous. Je veux réitérer mes remerciements à tous ceux qui m'ont aidé à accomplir la tâche dévolue à moi, c'est-à-dire aux membres du comité exécutif et du conseil d'administration, aux officiers supérieurs et au personnel du secrétariat.

Je formule le voeu que l'Association des Hôpitaux du Québec, après avoir vaincu les difficultés du début, continue son oeuvre d'éducation toujours orientée vers le bien commun. ■

Hospitals of Quebec

ASK TO BE ASKED

J. Gilbert Turner
M.D., C.M., M.Sc., F.A.C.H.A.
Montreal, Que.

A NEW era of hospital management was inaugurated in this province on January 1, this year, with the implementation of Bill 2, an Act of the Legislative Assembly of Quebec, to establish hospital insurance.

All ten provinces now have a government-sponsored plan of hospitalization based upon and in conformity with the federal Bill 320, entitled Hospital Insurance and Diagnostic Services Act.

Bill 2 is administered by the Minister of Health through the director of the Quebec Hospital Insurance Service in accordance with the provisions of that Bill and the provisions of the agreement between the Government of Canada and the Government of the Province of Quebec. Bill 2 provides that a resident of Quebec, *i.e.* a person who is legally entitled to remain in Canada and who makes his home and is ordinarily present in the province, is entitled to insured services without charge. These services will eventually include both in-patient and out-patient facilities but at the moment only in-patient services are available.

In-patient services in a hospital except in a tuberculosis hospital or sanatorium, a hospital or institution for the mentally ill, a nursing home, a home for the aged, an infirmary or other institution, the purpose of which is the provision of custodial care, are as follows:

1. Accommodation and meals at the standard ward level.
2. Necessary nursing service.
3. Laboratory, radiological and other diagnostic procedures, together with the necessary interpretation for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability.
4. Drugs, biologicals and related preparations, which, in the judgement of the physician, are required in accordance with accepted practice and sound teaching and are administered in the hospital. Preparations sold under the Proprietary or Patent Medicine Act are excluded.
5. Use of operating room, case room and anaesthetic facilities including necessary equipment and supplies.
6. Routine surgical supplies.
7. Use of radiotherapy facilities where available.
8. Use of physiotherapy facilities where available.
9. Services rendered by persons who receive remuneration thereof from the hospital.

Traditionally, hospital in-patient accommodation has been of three classes: public ward, semi-private and private. Quite correctly, Bill 2 uses the term "standard ward" instead of "public ward".

Insured in-patient services are those at the standard ward level. Regulations provide that each hospital maintain at least 40 per cent of its beds for standard ward patients. Those wishing semi-private or private accommodation pay a daily differential to the hospital of which the latter retains 40 per cent and the provincial government receives 60 per cent. After some trial runs, the semi-private differential for all hospitals of the province was set as of March 1, as follows:

1. On the Island of Montreal: a two-bed room—$5 per day; three- and four-bed rooms—$4 per day.
2. In the province outside of Montreal: two-, three- and four-bed rooms—$4 per day. Any room of five beds or more is rated as standard ward.

With regard to the differential for private rooms, the lowest rate in Montreal is $8 per day and in the rest of the province $7 per day. Higher figures are allowed for more expensive rooms provided that the increase is on the same order as existed on December 31, 1960. For example, a Montreal hospital in 1960 had three classes of private rooms for which they charged $20, $22 and $25 per day, the increases being $2 and $5 respectively over the basic rate. The differential which the same hospital can charge for the same rooms today is $8 plus $2 plus $5 or $8, $10 and $13.

In the early months of 1960 the officers and members of the Quebec Hospital Association spent innumerable hours in the preparation of a brief to the newly formed Hospitalization Insurance Inquiry Commission. Likewise, many of

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From an address presented to the third annual convention of the Quebec Hospital Association, Montreal, April, 1961.

The author is executive director, Royal Victoria Hospital, Montreal, and now president, Quebec Hospital Association.

Dr. Jules Gilbert, director of the Quebec Hospital Insurance Service, right, chats with Miss M. C. Freeman, director of dietary service at Queen Mary Veterans' Hospital, Montreal, and Dr. Gilbert Turner, now president of the Q.H.A.

our members, together with members of allied professions, were released by their institutions for part-time or full-time duty to serve on the Commission. It was a great pity that, because of the sudden dissolution of the Commission, these people were not permitted to complete their task. The vast amount of information amassed about the operation, financial aspects, responsibilities and the community requirements of hospitals should be recorded. It is our hope that the work of compiling this information is suspended only temporarily, and that it will be taken up in the very near future by a similarly competent group. I venture to suggest that only with such complete information can we properly realize our problems and propose reasonable procedures for their solution.

And so in June of last year when there was a change in the provincial administration, your association was ready to make its views known. To strengthen our appeal, we arranged that at our first meeting in Quebec on July 22 with the Hon. Jean Lesage, Premier of the province, and the Hon. Alphonse Couturier, Minister of Health, we were joined by members of the Provisional Committee of the Catholic hospitals of the province. Thus our delegation, which numbered 14, was able to say that we spoke for the hospitals of the province.

The very important principles contained in the brief submitted are listed here with comments.

1. A hospital insurance scheme in the Province of Quebec must benefit all residents of that province on a compulsory and contributory basis.

Comment: Although the brief did not spell it out, it did infer that substantial additional funds must be raised, either on a direct or indirect contributory basis, to finance the plan.

2. A hospital insurance scheme must provide benefits for all hospitalized persons, and the formula of reimbursement to hospitals must include cost of hospitalization at the standard or public ward level. Further, the reimbursement formula must recognize the variation in costs among different hospitals.

Comment: I am sure that our budgets for the current year have been submitted in keeping with this principle and we trust that when the budgets have been approved, we will find that this principle has been followed.

3. Provision must be made to cover the cost of out-patient care in order to avoid the unnecessary use of in-patient beds.

Comment: We are already aware that it is the government's intent to institute out-patient benefits gradually at the earliest convenient date.

4. Hospitals must be permitted to charge and retain a differential rate for semi-private and private accommodation.

Comment: In comparison with the differential rates established in other provinces, I think that ours are reasonable to both patient and hospital. We were disappointed that, in the absence of any direct benefits for the ten per cent, our share was arbitrarily set at 40 per cent, rather than the 50 per cent which does obtain in other provinces. We were told that the government needed this extra ten per cent to help finance the plan. The Quebec Hospital Association does not agree with this view as it feels that the ten per cent would be of inestimable help to many hospitals in discharging their present capital debt.

5. The existing debts of hospitals related both to operating deficits and capital expenditures should be examined and arrangements made for their orderly retirement in a manner consistent with sound financial administration.

Comment: Preliminary study and review show that the existing debt of the hospitals of this province totals tens and tens of millions of dollars. I would hesitate to give an exact figure. It is a basic premise that before one can deal with a problem one must know what the problem is. I submit that just as the individual wage earner cannot do his best if weighed down with worry, and even desperation, by heavy debt, neither can a hospital provide the good service its community requires of it, if it must carry the millstone of debt about its neck—frustrated by inability to program the retirement of that debt.

Accordingly, what is needed, and immediately, is a comprehensive study, which could well be accomplished in four months, by a competent impartial group to determine the exact debt situation of each one of our hospitals. Then, having the total picture, the group could consider ways and means of solving the problem which, by its very magnitude, will require long-term arrangements according to a definite formula of amortization. If such a study were undertaken without delay, then by the time the statistical portion were ready, the Quebec Hospital Insurance Service would have had experience in the first months of operating the plan. This, of necessity, would have a direct bearing on any decisions reached regarding the establishment of the formula for amortization.

This impartial group should have the status of a commission with all the necessary powers by law to obtain all the information required. I would suggest that its chairman be a justice of the Superior Court. Two members might well be from recognized firms of chartered accountants. The technical help of three to five members we willingly offer from this association.

With respect to existing debt

(continued on page 76)

His Eminence Cardinal Léger was guest speaker at the banquet.

at Q.H.A. meeting

emphasis on

Hospital Insurance

Jessie Fraser

The third annual meeting of the Quebec Hospital Association was held this year in April, 19 to 21, a happy change in timing because it meant good weather. At earlier meetings, held in March, those who attended were buffeted by wintry blasts, and all too often speakers were late because of road conditions. This year the sun shone for the most part, and attendance was excellent. The all-inclusive registration was over 1,800. The setting was, once again, the Queen Elizabeth Hotel with its fine facilities for both meetings and exhibits. There were over 100 displays by some 76 companies and the program allowed plenty of time for viewing by delegates and visitors.

This meeting was, of course, bilingual and there was simultaneous translation into English or French as the case might be. The dainty transistor units, with which almost every one was provided, were efficient but had one drawback. The ear piece is for one ear only and unless you have an ear muff handy you hear the address in both languages simultaneously —which can be a little wearing and sometimes even amusing.

At the opening ceremonies a certificate of honorary membership in the association was presented to Dr. Alphonse Couturier, Minister of Health, province of Quebec, by Dr. Paul Bourgeois, Q.H.A. president. Two related organizations meeting at the same time were the Province of Quebec Association of Hospital Auxiliaries and the Quebec Dietetic Association. Delegates from these allied societies were warmly welcomed to sessions of the Q.H.A.

Representatives of some 20 interested organizations in all were guests of the association. In his opening remarks the president, Dr. Paul Bourgeois, said of them: "Their active participation in our meetings will demonstrate to them the absolute necessity for the scientific and administrative autonomy of our voluntary hospitals."

Guest of honour at the opening luncheon was the premier of the province, the Hon. Jean Lesage. In his address, Premier Lesage appealed to hospital and medical associations to send suggestions to the government to help in the drafting of a Quebec Hospital Act. Unlike other provinces, Quebec has never had such an act and the 40-year-old Public Charities Act is obsolete. Said the premier to his audience: "The best hospital law will be the one which you inspire." But, he said, hospital and medical authorities must confer among themselves in order to find a formula acceptable to all parties.

Insurance

The hospital insurance plan, which came into operation in Quebec as of January this year, was naturally the subject of intense discussion, and much time was devoted to it. Speaking for the government, Dr. Jules Gilbert admitted that the plan still had certain weaknesses to be ironed out. It was drawn up in haste and with restricted personnel but haste was important, he said. He regretted the multiplicity of hospital organizations in that province which makes it difficult to consult with hospital authorities and to obtain a viewpoint common to all. It is impossible, he said, to consult with each of these groups before making decisions.

Concerning budgets for 1961 which were still under review, Dr. Gilbert noted the sudden increase in salaries and especially the amounts being paid out for special duty nursing. He pointed out that physicians and hospital authorities have a responsibility to interpret correctly the term "necessary nursing care" which is what the plan covers. "Any abuse leads inevitably to controls," he warned.

Jean-Paul Marcoux, speaking also for the insurance plan, felicitated hospital people in general for their ready co-operation with government officials. He indicated that the per diem rates set for 1961 were based upon 1951 costs and the average cost for three years prior to that. The estimated cost of the plan for 1961 he placed at $125,800,000 but expressed concern at the sharp rise in operating costs for 1960, as indicated by budgets submitted for 1961.

Dr. Gilbert Turner, executive director of Royal Victoria Hospital, Montreal, then spoke on behalf of the hospitals. He complimented Dr. Gilbert upon the tremendous task which he and his small staff had undertaken in introducing the plans so quickly. Dr. Turner urged the immediate establishment of an independent hospital commission to study the problem of existing capital debt among the hospitals of that province. The total amount runs into millions of dollars and

A total registration of some 1,800 kept the staff busy.

hospitals are hampered by this drag even though the daily operating cost is now covered by the insurance plan. He urged further that budgets for 1961 be approved as quickly as possible and pointed out that it is folly to provide more general hospital beds before proper provision is made for convalescent and long-term patients. He requested that the government look again at the salary ceiling for medical specialists as he feared that these physicians, essential to hospital service, would not be attracted to the hospitals in Quebec under the present situation. For the full text of Dr. Turner's forthright and persuasive address see page 53.

In the ensuing discussion, government officials answered questions freely, insofar as they were able. Dr. Gilbert assured his listeners that, where necessary, financial adjustments would be made at the end of the year to cover the real cost of hospital operation.

Association Activities

In his presidential report Dr. Paul Bourgeois outlined the activities of the association during the past year. A major effort, he said, was preparing a brief on the subject of hospital insurance which had been submitted to the provincial government. He recalled that delegations of hospital representatives had met with the Hon. Jean Lesage last June and again in August, and he regretted that certain promises made by government officials had not yet been carried out, *e.g.*, establishment of a committee to study and find a solution to the problem of hospital debts; and another to establish hospital standards.

Dr. Bourgeois enumerated the committees established during the year as follows: committee on professional secrets; on dental services; Blue Cross committee; and a private hospitals committee. Each of these had submitted reports to the executive, he said.

Under the heading of education, Dr. Bourgeois reported that the association had organized study sessions on the following topics: personnel administration, hospital-physician relations; nursing; dietetics; accounting and budgets; housekeeping; linen and laundry; and purchasing and stores. These meetings were organized with assistance from the University of Montreal, Hôpital Notre Dame and Hôpital Ste-Justine in Montreal, and for their success he gave much credit to the association's director, Dr. Gérald LaSalle. Those who attended expressed great satisfaction and requested more sessions of similar types. All meetings were bilingual.

Dr. Bourgeois stressed the association's rôle in public relations on behalf of the hospitals and mentioned the news bulletin which now goes out regularly.

Because of the problems which arise from the study of many documents and contracts, as well as requests for information from member hospitals, it was found necessary, the president said, to name a legal advisor to the association. He is M. Marcel Piché, the first president of the Q.H.A., whose "experience, prestige, and reputation will be a precious help to us," said Dr. Bourgeois.

In closing, the speaker reiterated the aim of the association—unity among the hospitals of the province. The text of Dr. Bourgeois' address appears in French on page 51.

New Officers

Dr. J. Gilbert Turner, executive director, Royal Victoria Hospital, was elected president of the association. He succeeds Dr. Paul Bourgeois, who was named honorary president. Sr. Noémi de Montfort, Hôpital Ste-Justine, Montreal, was elected vice-president. Jacques Bouchard of Amos, was re-elected treasurer.

Other members of the executive committee: Dr. David Beaulieu, Quebec; Sr. Mary Melanie, St. Mary's Hospital, Montreal; K. M. Nicholson, Jeffrey Hale Hospital, Quebec; Albert Nantel, Administrator of Hôpital Ste-Jeanne

Chatting at a press conference, from left to right: John M. Partlo; William Dodge of the Canadian Labour Congress, Ottawa; Prof. Louis-Philippe Brizard, University of Montreal; Ray Clark, Royal Victoria Hospital; and Dr. R. F. Ingram, Children's Hospital, Montreal.

Newly-elected officers for the coming year. Front row: Sr. M. Melanie of Montreal Dr. Paul Bourgeois, honorary president. Back row: Jacques Bouchard of Amos, treasurer; Dr. C. A. Roberts of Verdun; Dr. Gilbert Turner, president; Kenneth Nicholson of Quebec City. Absent from this picture are; Dr. David Beaulieu of Quebec City; Sr. Noémi de Montfort, vice-president and Albert Nantel of Montreal.

d'Arc, Montreal; and Dr. C. A. Roberts, medical superintendent, Verdun Protestant Hospital.

There is also a board of directors with 14 members.

A Plea for the Human Touch

His Eminence Cardinal Léger, the guest speaker at the banquet, said that modern hospitals run the risk of being dehumanized by science and technology. With growing specialization and increased technology, little time is left for human contact with patients.

"I know that hospital administration is harassed by budgets and the need of co-ordinating innumerable services," he continued. "Still, hospitals must not be organized into rigid and inflexible systems."

He said that many methods have been used to add some human warmth in hospitals — modern furniture, telephones, radios and television.

"But we must not expect material surroundings to give the human touch that should come from doctors, nurses, and personnel in general," he said. "A patient might wonder whether we have not contrived for material comfort to make him forget the human indifference that surrounds him."

He sees a hospital as a laboratory where medical science continued to move ahead with giant steps. But it must also be a place of welcome where the dignity of the patient is given prime consideration.

Trusteeship

A guest speaker from south of the border was Raymond P. Sloan, associate professor of administrative medicine, Columbia University, who addressed delegates on the subject, "The Responsibility of the Trustee". According to Mr. Sloan the right kind of trusteeship invariably involves personal sacrifices. Trusteeship is an honour to be earned—not something thrust casually upon certain privileged individuals blessed with riches or social position. The speaker indicated that, across the continent, there is an awakening of hospital trustees to their seri-

Centre: Sr. Archambault of Hôpital Maisonneuve, Montreal. Left and right: Sr. Margaret Lemyre and Dr. Lucien Lacoste, both of Hôpital Notre Dame, Montreal.

A guest speaker from Ontario, John Hornal of the Ontario Hospital Services Commission, talking shop with Dr. H. S. Hooper of Grandmère and Gaspard Massue of Hôpital Sainte-Justine, Montreal.

ous responsibilities and the need for greater knowledge to ensure their competency in fulfilling their obligations. "Trustees are willing to take time from their busy schedules to familiarize themselves with hospital affairs," he said.

To quote Mr. Sloan further: "The greatest inadequacy of trustees . . . lies in their inability to appraise and gauge professional procedures. This is only to be expected. But what cannot be so easily dismissed is their frequent unawareness of their responsibilities in this respect.

"I'd like," he continued, "to see a well-organized and carefully executed orientation program for every new trustee . . . and refresher courses for those who have served long terms as board members. This is essential because of the changes that are taking place in modern health services."

Labour Relations

On this topic delegates were addressed by William Dodge of Canadian Labour Congress, Ottawa, and there followed a panel discussion. On stage were: Jacques Archambault of the Confederation of National Trade Unions, Quebec; Prof. Louis-Philippe Brizard from the University of Montreal; Samuel S. Cohen, executive director of the Jewish General Hospital, Montreal; Albert Nantel, administrator of Hôpital Ste-Jeanne d'Arc, Montreal; and John Partlo, executive director of Queen Elizabeth Hospital, Montreal.

Those who work in hospitals should receive the same consideration as workers in industry, Mr. Dodge pointed out, *i.e.* reasonable security and fair treatment. They should have the right to bargain collectively and to negotiate. He did recognize that in other respects hospital work is different. While hospital employees have legal rights, they also have a moral responsibility for the care of the sick. The public expects of them a charitable attitude and sometimes advantage is taken of this, he said, to justify poor working conditions and low salaries. The speaker deplored the fact that hospital employees, while finding great satisfaction in their work and becoming quite dedicated, all too often are expected to subsidize welfare. This burden, he emphasized, should be carried by the public in general and not by individual workers. Board members are apt to be less liberal toward hospital employees than they are toward those in their own business or profession because hospitals always have deficits; and, of course, Sisters find unions quite foreign to their own sense of devotion. Mr. Dodge pleaded for improved wage scales and admitted that progress is being made in this respect across the country. It makes no sense, he said, to keep salaries too low because in that case hospitals will not retain high calibre employees. In his opinion administrators should welcome unions as a benefit to the hospitals of the nation. He pointed out that patients, or the public, must be prepared to pay for the care expected and that, while hospital strikes are almost unheard of in Canada, the right to strike leads to serious arbitration.

Mr. Dodge was complimented upon his brevity and obvious sincerity. However, ensuing discussion would indicate that not all those present were convinced that union activities are entirely humanitarian.

Long-term Illness

At a session held especially for medical social workers, the theme was "Long-term Illness under Hospital Insurance." Dr. Ronald Bayne, consultant in geriatrics at Ste. Anne's Hospital in Ste Anne de Bellevue, and Queen Mary Veterans Hospital in Montreal, defined the long-term patient as one who requires hospital care for more than 30 days. He or she may be any age and the condition may be an acute illness from which recovery is slow, or it may be a chronic illness. Beyond the acute stage, special treatment rather than general hospital care is required. We must establish, he said, rehabilitation units which are affiliated with general hospitals. Also needed are supervised homes and home-care programs for those who need some help. In all cases, Dr. Bayne urged, treatment should be vigorous and aimed at returning the patient to the highest possible degree of independence. The financial and social implications of rehabilitation are tremendous, he said, and this should be a con-

(continued on page 92)

Strolling between sessions, from left to right: Sr. Ste-Vincent, Sr. Ste. Léonide, Sr. Marie de la Providence, Sr. Marie du Divine Coeur (all of Three Rivers), and Sr. Camille of Montreal.

You can CONVERT existing sterilizers to HIGH VACUUM

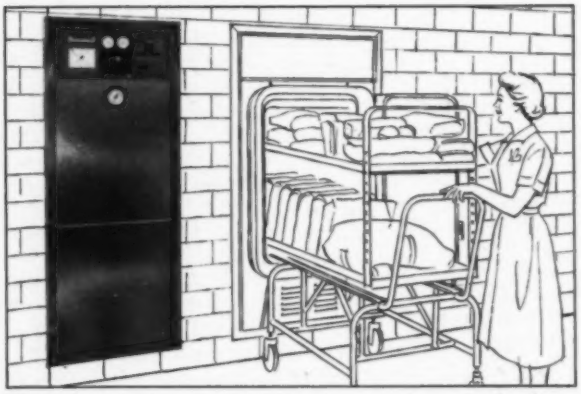
by Richard D. Castle

NO. 3 IN A SERIES

This is the third in a series of articles on High Vacuum Sterilization and how it brings greater safety and efficiency to hospital sterilization. Its author is Richard D. Castle, head of Research and Development, Wilmot Castle Company, Rochester, N.Y. Working with the Drayton Regulator & Instrument Co., Ltd., of England, Castle has developed the OrthoVac* System in an exclusive console design, permitting on-the-site conversion of existing "downward displacement" steam sterilizers to the revolutionary high vacuum process.

● High Vacuum Sterilization promises new rewards in the hospital's constant search for safer and more efficient sterile techniques. Processing times one-fourth those of present day "downward displacement" sterilizers, safety in the certain killing of bacteria, and the reduction of damage to goods are advances of real significance.

● Realizing that many hospitals have only recently purchased expensive steam sterilizing equipment, we decided early to produce our OrthoVac High Vacuum System in the form of console "conversion kits." Conversion of any existing steam sterilizer is a simple, on-the-site job. The hospital enjoys the advantages of high vacuum modernization without having to obsolete present equipment.



Typical conversion unit with console recessed next to sterilizer.

● Performance of the "converted" High Vacuum Sterilizer is generally very nearly as good as the "all-new" installation. The lower design pressure of most older vessels somewhat restricts their useful temperature range. A 17 psi design, for example, limits temperature to about 250° F., whereas new higher-pressure vessels specially built for the vacuum process will support temperatures up to 275° F. Overall cycle time for the 36 psi OrthoVac high pressure type is just 15 minutes, with approximately 27 minutes required for a 17 psi OrthoVac conversion. Despite the greater speed of the newer vessel, the converted sterilizer cycle is still a vast improvement over the one-to-two hour "downward displacement" cycle now in use.

● Aside from the vast improvement in overall speed, the converted high vacuum sterilizer has tremendously increased capacity. Since air elimination is no longer a problem, dense packaging and loading are perfectly safe. Generally speaking, a 25% increase in output per load may be expected from existing equipment upon its conversion. The life of goods sterilized is also materially increased.

● The safety afforded is, of course, of first importance. With the drawing of a near-absolute vacuum, uniformity of temperature throughout the load is obtained within a predictable period, regardless of size of load or manner of packaging. Common errors in packaging and loading are no longer critical. And, sterilization becomes a mathematical certainty through use of an exclusive Time-Temperature Integrator. Based on established time-temperature requirements, the Integrator selects and controls the exposure period necessary for kill, automatically compensating for the normal rises and drops in temperature which occur throughout the cycle. The operator is relieved of all need to make manual time settings, thus saving time and eliminating possibility of error.

● The control console itself is designed for mounting next to the parent sterilizer in either wall-recessed or cabinet form. It comes equipped with an oil-seal vacuum pump, barometrically compensated pressure switch, automatic controls and interconnecting piping.

● Approximately 30 inches of wall space are required on either left or right of the existing sterilizer. In situations where space is a problem, retirement of an "extra" older sterilizer is often justified by the increased output of the new system.

● For successful conversion, the existing parent vessel should be of welded design to prevent leakage under vacuum conditions. The higher the design pressure, the shorter the cycle. Any size or make of vessel may be converted. Full economy of the high vacuum system is better realized, of course, in vessels of larger size.

● Installation is quite simple. Existing steam supply lines and drains may be used. Piping and controls are stripped from the old sterilizer, and direct connection made to the console. The console is then connected to existing services. Occasionally a water supply for condensing the steam and electric current for operation of the console controls must be added where they do not already exist.

● First High Vacuum conversions in U. S. hospitals will be made this year with OrthoVac Consoles. Our affiliates at Drayton have already made well over 200 such conversions in England. A wealth of experience will be at your disposal should your hospital join the many others modernizing by converting or with all new OrthoVac Systems.

For further information on OrthoVac write for Bulletin H-283.

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What you should know about *food additives*

K. M. Render
Winnipeg, Man.

IT has been said that the possible origin of "food additives" rests with our ancestors when they found that by preserving their meat with salt, it could be safely stored for a longer period of time.

Since then many technological advances have been made in the food industry, and that research now provides a wide variety of additives for different uses.

It is this great number of additives, their purpose, and safety that is of interest to the consumer, home economists and dietitians. In a recent address Dr. Elizabeth Todhunter, dean of the School of Home Economics, University of Alabama[1], spoke of this problem.

"We realize that serious and difficult problems face agriculture and the food industry in maintaining an adequate supply of food for our people. There are problems of (a) contamination during production, (b) processing which may cause loss of nutritive value, (c) transportation and storage, (d) packaging, and (e) labelling.

"In order to produce food today, pesticides must be used to destroy or control the activity of insects, weeds, fungi, bacteria, and other pests that attack crops and livestock. This tremendous problem presents a challenge to the chemist to develop effective pesticides and a challenge to those agencies responsible for maintaining the safety of our food to see that nothing remains on the food of a kind or in an amount to be a health hazard."

The officers of the Food and Drug Directorate in their administration of the Food and Drugs Act are well aware of this challenge.

A review of the steps leading up to the present legislation takes us back to 1874 when the Canadian Parliament passed "The Inland Revenue Act", prohibiting the sale of a food containing any injurious or poisonous ingredients. Ten years later in 1884 the Act was replaced by the "Adulteration Act" which made provision for declaring an article of food to be "adulterated" and during the subsequent period many changes have been made based on the needs of the time. The present "Food and Drugs Act" which was passed by the Canadian Parliament in 1954, evolved from these revisions.

That then, is a brief historical picture of the past, and before discussing the present and the future the following generally accepted definition of a food additive is quoted for future reference insofar as this article is concerned. It is convenient to divide this definition into two general groups:

1) intentional additives are substances used in the manufacture or formulation of a food for the purpose of imparting some desired quality or to perform some function. For example, the synthetic flavours and food colours are used to enhance attractiveness and to standardize variability in raw material, while the preservatives and antioxidants are added to prevent spoilage, prolong shelf life, to conserve seasonal surpluses and thus prevent food wastage. Nutrients such as vitamins, minerals and proteins are added to improve nutritional quality of processed foods.

2) incidental additives are substances present in foods as a result of their production, processing or storage. The pesticides and fungicides belong to this group. They do not impart any desired quality to the final product but are necessary in protecting food crops from the ravages of insects, moulds, fungi, et cetera. As a result of their use, low levels of residues of these chemicals are often present in the food.

Intentional Additives

In covering the intentional additive field, it can be seen from a review of the Food and Drug Regulations[2] that this may be broken down into several groups, some of which are discussed.

Preservatives

Preservatives are a type of additive which has been with us for the longest period of time and to fall into this class they usually have as their purpose the prevention of microbiological spoilage (antimicrobial), mould or rope inhibitors (antimycotics) or rancidity in fatty foods (antioxidants). For convenience of administration they have been placed in one of four groups referred to as Class I, II, III and IV.

Permitted levels of use for many of these are included in the Regulations and the following is a

(continued on page 63)

From an address presented to the Manitoba Home Economics Association, November, 1960. The author is superintendent of Inspection Services, Food and Drug Directorate, Department of National Health and Welfare.
[1] For references see page 109.

Food Additives

(continued from page 60)

brief list of these, in their various groups:

Class I — Salt, spices, vinegar, et cetera.

Class II — Benzoic acid and sulphurous acid.

Class III — Sodium propionate, sorbic acid (mould and rope inhibitor).

Class IV — propylgallate, butylated hydroxyanisole and others.

Food Colours

The colours allowed by regulation to be used in food are limited to natural colours, caramel, specially purified charcoals, carbon black, iron oxide, titanium dioxide and coal tar colours for which standards are prescribed.

The regulations covering coal tar colours limit their use to one part in 3500 parts by weight of the food and each of the colours is the subject of a standard. The regulations require that all lots of coal tar colour be certified as complying with these standards before they may be sold in Canada. It has been necessary over the past few years to delete from the permitted list several food colours which on more advanced toxicological testing were found to be questionable with regard to long term toxicity.

General

In this class, I should mention the following types of additives; neutralizers, thickeners, glazes, humectants, anti-hardening agents, chillproofers, sequestrants, clarifiers and buffers. These are all additives which have a useful technological purpose, and chemicals falling within these groups are controlled under the general sections of the Act.

Nutrients

Specific regulations are in effect with regard to the additions of vitamins to food. For standardized foods such as bread, apple juice, evaporated milk, the addition is allowed by specific regulations covering the standard. The minimum and maximum amounts of the allowed vitamins are listed in the standards. For unstandardized foods such as cereal products, pudding powders, the amounts of vitamins which may be added are controlled as follows:

The regulations require that where vitamins are added to the food, the amount supplied in a reasonably daily intake satisfies the minimum quantities stated; *e.g.* for a product such as "grape drink" to which has been added vitamin C, one eight-ounce glass should supply a minimum of 20 mg. of ascorbic acid and not more than 60 mg.

The minimum limits for vitamins have been set to preclude advertising advantages where only insignificant amounts have been added, and the upper limit is in effect to prevent any possible health hazard and to discourage the consumer from purchasing more than the body could be expected to need.

The Directorate discourages the addition of vitamins to food unless, of course, it can be shown that the additions are required for maintaining good nutrition or for arresting vitamin deficiencies. Of course, the food itself should be an effective vehicle for the nutrients and, also, the nutrients should be physiologically available at time of purchase by the consumer.

Other nutrients which may be added to foods either directly or by a choice of specific food ingredients from a particular source are minerals and proteins. The addition of minerals to food is not widespread, but where the addition is made it is usually controlled by the standard. An example of this would be the addition of potassium iodide to iodized salt.

The protein picture is a little different since protein components are chosen from various sources such as soya, milk, eggs and meat and, of course, synthetic amino acids. The problem here is mainly one of advertising and it is felt that since the Directorate has taken an active interest in this field in attempting to set up standards for "quality of complete protein" based on biological response, the tone of advertising has been kept at a sane level in a highly competitive field.

Food Service

sponsored by the

Canadian Dietetic Association

Incidental Additives

Under the existing regulations, provision is made for the establishment of tolerances for chemicals which may be present as "incidental additives" in food and these are usually referred to as agricultural chemicals.

A request for the establishment of a tolerance usually originates with the firm which has developed the chemical and before any consideration is made regarding this tolerance, the following information must be supplied to the Directorate:

(1) the chemical name, the trade name and, where applicable, the purity, stability, solubility, melting point, vapor pressure and density;

(2) the amount to be applied and the frequency and time of application;

(3) full reports of investigations made to determine safe levels (these reports to include, where necessary, data and detailed information obtained from appropriate animal or other biological experiments in which the method used and results obtained are clearly set forth);

(4) the results of tests on the amount of residue remaining in or on the food crop and the description of a satisfactory analytical method for determining residues in or on foods or classes of foods for which it is recommended; and

(5) a proposed tolerance.

In addition, it is requested that where toxicological work is reported, a description of the method used, the number and species of animals used in biological tests, a description of the statistical design and analysis of such tests, and the results and conclusions drawn should be clearly stated.

It is not felt that the existing procedure has allowed the introduction into our food supply in recent decades of any substance which has been shown to have had a harmful effect on the health of the consuming public. There have been several instances where additional toxicological evidence has shown a substance to be more toxic than originally thought. In these cases, to prevent any possible harm, these compounds have been withdrawn from use. Coumarin and the yellow colours, yellow AB and OB, are examples of such compounds.

What is Safety?

As you can see, our primary concern is to ensure safety in the use of any additive in food. This brings up an obvious question—what is safety? Safety has been defined as the practical certainty that injury will not result from the use of a substance in a proposed quantity and manner. The probability that injury will result is often referred to as the hazard, and toxicity as the capacity of a substance to produce injury. The hazard may be more specifically defined as the injury produced by the ingestion of small amounts of an additive over long periods of time.

No doubt many of you will be

(continued on page 106)

SUDS

• how short is a short formula?

• soil removal factors

M. D. Dawes,
Toronto, Ont.

THE next step of the washing process as outlined in the previous article (see *Canadian Hospital* May, page 66) is the suds cycle. In this part of your formula, the soap or synthetic detergent of your choice is used. This choice is an important one, for soap is the most important supply in the washroom and it takes good soap to remove dirt and soil efficiently. The purpose of the suds bath is to loosen, emulsify and remove all the dirt from the fabrics being washed. However, in the process of doing this, two important factors must be considered:

1. the original colour of the clothes must be maintained — the white clothes must not become grey or yellow and coloured fabrics must stay bright and unfaded; and

2. the original strength of the fabric must be maintained within limits.

The soil present in the clothes which go to your laundry may be put into three classifications:

1. water soluble soil, *e.g.*, starch, sugar, fruit juices, perspiration, et cetera;

2. water insoluble oily soils, *e.g.*, butter, lard, vegetable and mineral oils; and

3. water insoluble non-oily inert soils, *e.g.*, soot, carbon, finely divided earth, et cetera.

Science plays a definite part in the development of better, more thorough and rapid washing. However, it is not necessary to complicate the washing of each individual load or even the problem of setting up washing formulae by mixing chemistry with the control of dirt removal. Simply follow the fundamentals of good washing which are: (a) a sufficient number of heavy suds; (b) adequate sudsing time; (c) correct temperatures for each type of work; and (d) enough good, properly built, soap or synthetic throughout the suds cycle.

A heavy suds indicates that sufficient soap is present for good washing in contrast to a light, runny or beady suds. When the suds fall, it means that the soap has been used up and the work is likely to become grey because there is not sufficient soap to keep the dirt emulsified. Consequently, the dirt is re-deposited on the fabric by the mechanical action of the washer. As we all know this re-deposited dirt or soil is more difficult to remove from the clothes than it was in the form of natural soil; that is, in its original state.

The number of suds and the total sudsing time depend upon the condition of the load and vary with different types of work. For example, lightly soiled linen frequently can be washed with just one or two suds, while the more heavily soiled work may require as many as four or even five suds. Sudsing time may vary with the class of work being washed. However, it must be sufficiently long to remove the dirt from the clothes and put it into suspension so that it can be flushed away.

The selection of the right soap or synthetic detergent is very important. For high temperature washing of white work, a good high titre built soap or a high titre neutral soap properly built should be used. For low temperature washing, a good low titre soap or one of the synthetic detergents will ensure quality as well as safety, particularly when washing colours. Silks, wools and rayons present a different problem, of course. For these delicate fabrics, a fine, good quality, neutral soap or, again, one of the synthetic detergents assures greater safety to fabric and colour.

An important factor connected with the suds operation is the water level or levels of the various suds baths. The right water levels for the suds baths have been determined by research and practical experience. When washing open work, it is suggested that we use a five-inch level on the first suds, a three-inch level on succeeding suds and a five-inch level on the bleach or last suds. When nets are used, add two inches to all the water levels used on open work.

We mentioned a few moments ago that correct temperatures for each type of work was one of the basics or fundamentals of good washing. The temperatures of the suds baths are certainly very important because they are directly related to soil removal. Years ago it was thought that the first operation for white work should be run in tap water. The theory behind this cold water usage for the first suds was to prevent any blood and albuminous stains from setting in the fabric. Later tests showed that temperatures of 110 to 120 degrees F. would give increased dirt removal in this first operation and yet not set stains. These starting temperatures make it easier to reach the high temperatures which are of course necessary on succeeding suds for quality washing. This is particularly true in plants where steam is not used on the wheel and where they depend on the hot water supply alone to get high temperatures. On subsequent suds, the temperature should be raised as rapidly as possible to at least 160 degrees F.

Fugitive colours, silks, wools and rayons should not be washed over 100 degrees F. The fast colours

(concluded on page 88)

The author is western divisional field manager of the Procter and Gamble Company of Canada, Limited.

New "Tulip Design" 5-oz. cup and Griptite® lid prevents spillage, ends breakage!

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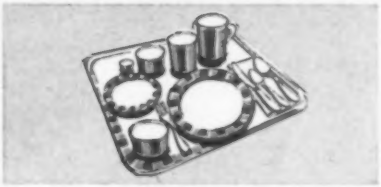

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with the auxiliaries

Junior Auxiliary Celebrates Tenth Anniversary

The Junior Auxiliary of Douglas Memorial Hospital, Fort Erie, Ont., was formed 10 years ago, largely through the efforts of the original auxiliary, which at that time had already served the hospital most capably since its founding in 1931. Feeling the need of assistance from women who were able to meet more easily in the evenings, they contacted several of the younger women of Fort Erie, and so the Junior Auxiliary was born. This energetic group, in the past decade has bought equipment, produced plays, provided funds for refurnishing the maternity ward and the paediatrics ward, and since 1957 a bursary has been offered each year to a high school student of the district interested in nursing as a career.

Women's Auxiliary Celebrates Sixtieth Anniversary

The 70-member Women's Auxiliary of the Orillia Soldiers' Memorial Hospital, Orillia, Ont., was honoured on its sixtieth anniversary at a banquet held recently. The guest speaker, the Hon. Dr. Matthew Dymond, Minister of Health for Ontario, described the history of the hospital movement from its beginnings in Egypt around 3,000 B.C. Past and present auxiliary members, and others credited with the hospital's progress, were honoured in an impressive candlelight ceremony. Over the years, the work of the members has resulted in a great many additions to the hospital and the nurses' residence; such as, stoves, refrigerators, automatic washers, an operating table, oxygen tents, a deep freeze, anaesthetic apparatus, and many more.

Providing Hospital Furnishings

The members of the Women's Auxiliary of Toronto Western Hospital, Ont. plan to furnish an interns' lounge and recreation room, and a sewing room and library for the auxiliary's own use. During the past year the gift shop realized $11,426. Work on a beautiful new shop will soon be completed.

Paediatric Ward and Nursery Extension

At the South Peel Hospital the Women's Auxiliary has embarked on a $50,000-project to furnish and equip the extension to the paediatric ward and the nursery. A handsome silver tea service was presented to the nurses as an expression of appreciation to them for their valuable co-operation.

Volunteer Workers Honoured by Hospital

Tribute was paid recently to a representative group of the 160 volunteer workers who perform many services to patients at the Owen Sound General and Marine Hospital, Owen Sound, Ont. Mr. William N. Hawkins, chairman of the hospital board, described the purpose of the meeting as an opportunity for the members of all groups related to the hospital to become better acquainted and for the hospital board and staff to recognize and appreciate the importance of the work being done by the volunteer workers. Mr. Hawkins said that the volunteers formed a bridge between the hospital and the outside, and that they have the opportunity to increase the community's knowledge of the hospital and its many services. As the hospital and its services expand in the future, the volunteer will become more important because the services provided by them help to keep hospital costs down.

Mrs. W. P. Telford, president of the Ontario Hospital Auxiliaries Association, pointed out that because volunteer groups were assisting such patient services as admitting, escort, mail delivery, reading and visiting, the staff was relieved of these duties and had the opportunity to direct their efforts into channels where specialized services were required.

Gift Shop Makes $58,600

For the second year of operation, the gift shop sales totalled $58,600 for the Women's Auxiliary of Doctors' Hospital, Toronto, Ont. This is an increase of $13,000 over last year's sales. From this $10,000 was set aside for future projects, and $1,500 was donated towards research work in the hospital. Planned for the near future is an expansion of the volunteer program to include such areas, as admitting, library cart, flower arranging for patients, central supply work and occupational therapy.

Progressive Patient Care Will Change Volunteers' Rôle

At the annual meeting of the Women's Auxiliary of the Queensway General Hospital, Toronto, Ont., the rôle of the volunteer in progressive patient care plan was outlined. Under such a plan patients are divided according to their degrees of illness into four zones. These are special care, where little volunteer aid will be needed; intermediate care, where volunteers will continue present duties; continuation, where they will have more scope than ever; and self service, for patients who are soon to leave for home or are awaiting surgery. Members were told that in the last two zones there will be great need for volunteers as card playing partners, readers and letter writers.

● The Ladies' Aid of the Prince County Hospital, Summerside, P.E.I., have purchased a cardiac pacemaker, valued at $345. In cases where the heart has stopped beating, this valuable machine, which is now ready for use at the hospital, is used to re-activate the heart.

● The Women's Auxiliary to the Rosamond Memorial Hospital, Almonte, Ont., realized about $700 from its "Party Week". Any and every excuse for a party was used both in Almonte and the surrounding district. There were card parties, dinner parties, tea parties.

● A cheque for $20,000 was presented recently to Abraham Posluns, president of the Jewish Home for the Aged and Baycrest Hospital, by its Women's Auxiliary. The gift represents the results of the group's fund-raising activities which consist of such projects as theatre nights at the O'Keefe Centre, and the inscription, birthday, and anniversary books which give members and the entire community an opportunity to honour friends.

● More than $2,000 raised by the Crofton Women's Auxiliary to Chemainus General Hospital, Chemainus, B.C., was used for the purchase of a magnifying lamp, 12 crib blankets, eight overbed tables, a radio for the ladies' ward, and a donation of $400 towards an x-ray machine.

● The White Rock and District Hospital, White Rock, B.C., shared in the proceeds of "Cinderella", a pantomime put on by the White Rock Players' Club. It was a tremendous success, and netted them $646.

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DR.D.PHYSICIAN 1234567
H/WIFE D596 10-10-61
JOHN T.PATIENT H03-0921
S/E CARPENTER 10.30PM
DR.G.SPECIALIST ORTHO SP

ADMITTED TO FLOOR AND ROOM NUMBER

HOSPITAL ADMISSION NUMBER
SEX, AGE, RELIGION MARITAL STATUS
HOSPITAL COMMISSION NUMBER
DATE OF ADMISSION
TELEPHONE NUMBER
TIME OF ADMISSION
TYPE OF ACCOMMODATIO
DIAGNOSIS

Canadian Hospitals *now accredited*

Marc Tardif, M.D.

Dr. Tardif became assistant to the executive director of the Canadian Council on Hospital Accreditation as of June 1. See *Canadian Hospital*, May, page 20.

THE names of Canadian general and special hospitals accredited by the Canadian Council on Hospital Accreditation as of December 31, 1960, appear hereunder. Hospitals devoted exclusively to the treatment of mental illness are not included. The C.C.H.A. has not yet approved standards for accrediting mental hospitals in Canada.

Good progress has been made since the Canadian Council on Accreditation took over the program from the Joint Commission on the Accreditation of Hospitals two years ago. But less than half the hospitals in Canada which are eligible for accreditation are accredited. This is because the number of eligible hospitals has been growing faster than the rate at which they are becoming accredited. This points up the size and challenge of the job still to be done, if, as the sponsors of the program believe, accreditation is to be the objective of every eligible hospital.

The accreditation program is a voluntary service extended upon request to any individual Canadian hospital which has 25 beds or more, has at least three active medical staff members, is licensed by the province, listed in the Canadian Hospital Directory, and has been in continuing operation for at least one year. Until a visit has been requested and a survey made, the accreditation status of a hospital cannot be determined. Any hospital which desires assessment and whose name does not appear on this list should start action now if it wishes to be identified as an accredited hospital in subsequent lists. It may take six months to a year from the time a request is received to arrange for a survey and determine a hospital's status. Therefore a request for survey should be made somewhat in advance of the target date by which the hospital expects to be able to meet the standards.

—W. I. Taylor, M.D., executive director, Canadian Council on Hospital Accreditation.

BRITISH COLUMBIA
CAMPBELL RIVER—Campbell River and District General Hospital
DUNCAN — King's Daughters Hospital
HANEY — Maple Ridge Hospital
KAMLOOPS — Royal Inland Hospital
KITIMAT — Kitimat Hospital
NANAIMO — Nanaimo General Hospital; Nanaimo Indian Hospital
PORT ALBERNI — West Coast General Hospital
POWELL RIVER — Powell River General Hospital
QUESNEL — G. R. Baker Memorial Hospital
ROSSLAND — Mater Misericordiae Hospital
SARDIS — Coqualeetza Indian Hospital
TRAIL — Trail-Tadanac Hospital
VANCOUVER
Burnaby General Hospital
Children's Hospital
North Vancouver General Hospital
Pearson Tuberculosis Hospital
Royal Columbian Hospital
St. Paul's Hospital
St. Vincent's Hospital
Grace Hospital
Shaughnessy Hospital
The Vancouver General Hospital
Willow Chest Centre
Mount St. Joseph Hospital
VERNON — Vernon Jubilee Hospital
VICTORIA
Queen Alexandra Solarium for Crippled Children
R.C.N. Hospital
Royal Jubilee Hospital
St. Joseph's Hospital
Veterans Hospital
ALBERTA
BANFF — Mineral-Springs Hospital
CALGARY
Alberta Crippled Children's Hospital
Baker Memorial Sanatorium
Calgary General Hospital
Colonel Belcher Hospital
Holy Cross Hospital
CAMROSE — St. Mary's Hospital
CASTOR — Our Lady of the Rosary Hospital
DRUMHELLER — Drumheller Municipal Hospital
EDMONTON
Charles Camsell Indian Hospital
Edmonton General Hospital
Misericordia Hospital
Royal Alexandra Hospital
University of Alberta Hospital
HANNA — Hanna Municipal Hospital
KILLAM — General Hospital
LAMONT — Archer Memorial Hospital
LETHBRIDGE — Lethbridge Municipal Hospital; St. Michael's General Hospital
PROVOST — Provost Municipal Hospital
RED DEER — Red Deer Municipal Hospital
VEGREVILLE — St. Joseph's General

(continued on page 70)

Accredited Hospitals
(continued from page 68)

SASKATCHEWAN

CANORA — Canora Union Hospital
FORT QU'APPELLE — Qu'Appelle Indian Hospital
FORT SAN — Fort Qu'Appelle Sanatorium
GRAVELBOURG — St. Joseph's Hospital
HUMBOLDT — St. Elizabeth's Hospital
MACKLIN — St. Joseph's Hospital
MELVILLE — St. Peter's Hospital
MOOSE JAW — Moose Jaw Union Hospital; Providence Hospital
NORTH BATTLEFORD — Notre-Dame Hospital
PRINCE ALBERT — Holy Family Hospital; Prince Albert Sanatorium; Victoria Union Hospital
RADVILLE — Radville Community Hospital
REGINA — Regina General Hospital; Regina Grey Nuns' Hospital
SASKATOON
Saskatoon City Hospital
Saskatoon Sanatorium
St. Paul's Hospital
University Hospital
TISDALE — St. Therese Hospital
YORKTON — Yorkton General Hospital

MANITOBA

BRANDON — Assiniboine Hospital; Brandon General Hospital
NINETTE — Manitoba Sanatorium
THE PAS—St. Anthony's Hospital; Clearwater Lake Hospital.
PORTAGE LA PRAIRIE — The Portage General Hospital
WINNIPEG
The Children's Hospital of Winnipeg
Deer Lodge Hospital
Grace Hospital
Misericordiae General Hospital
Shriners Hospital for Crippled Children
St. Boniface Hospital
St. Boniface Sanatorium
Victoria General Hospital
Winnipeg General Hospital
Winnipeg Municipal Hospitals
King Edward Memorial Hospital
King George Hospital
Princess Elizabeth

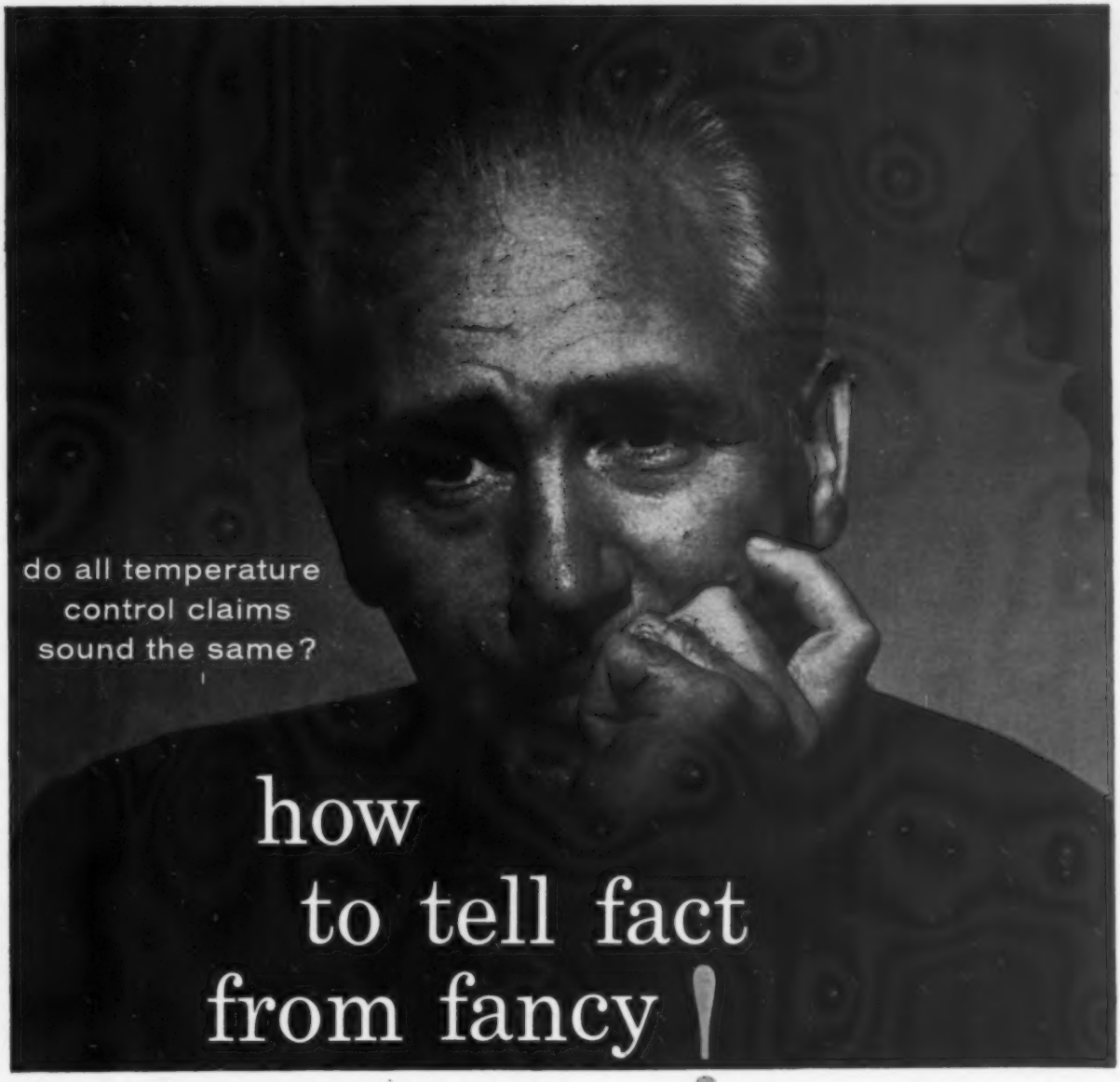
ONTARIO

BARRIE — Royal Victoria Hospital
BELLEVILLE — The Belleville General Hospital
BRANTFORD — Brant Sanatorium; Brantford General Hospital; St. Joseph's Hospital
BROCKVILLE — Brockville General Hospital; St. Vincent de Paul Hospital
CHATHAM — Public General Hospital; St. Joseph's Hospital
COOKSVILLE — The South Peel Hospital
COPPER CLIFF — International Nickel Company Private Hospital
CORNWALL — Cornwall General Hospital; Hotel Dieu Hospital
DEEP RIVER — Deep River Hospital
FORT ERIE — Douglas Memorial Hospital
FORT FRANCES — La Verendrye Hospital
FORT WILLIAM — McKellar General Hospital
GALT — South Waterloo Memorial Hospital
GRAVENHURST — Muskoka Hospital for the Treatment of Tuberculosis
GRIMSBY — West Lincoln Memorial Hospital
GUELPH — Guelph General Hospital; St. Joseph's Hospital
HAMILTON
Hamilton General Hospitals
The Mountain Sanatorium
St. Joseph's Hospital
St. Peter's Infirmary
IROQUOIS FALLS — Anson General Hospital
KINGSTON
Canadian Forces Hospital
Hotel Dieu Hospital
Ongwanada Sanatorium
Kingston General Hospital
St. Mary's of the Lake
KITCHENER — Freeport Sanatorium; Kitchener-Waterloo Hospital; St. Mary's General Hospital
LEAMINGTON — Leamington District Memorial Hospital
LONDON
Beck Memorial Sanatorium
St. Joseph's Hospital
Victoria Hospital
Westminster Hospital
NIAGARA FALLS — Greater Niagara General Hospital
NORTH BAY — North Bay Civic Hospital; St. Joseph's General Hospital
OAKVILLE — Oakville-Trafalgar Memorial Hospital
OHSWEGEN — Lady Willingdon Indian Hospital
OSHAWA — Oshawa General Hospital
OTTAWA
Canadian Forces Hospital
Ottawa Civic Hospital
Ottawa General Hospital
Royal Ottawa Sanatorium
Saint - Louis - Marie de Montford Hospital
OWEN SOUND — Owen Sound General and Marine Hospital
PENETANGUISHENE — Penetanguishene General Hospital
PETERBOROUGH — Peterborough Civic Hospital; St. Joseph's Hospital
PORT ARTHUR — The General Hospital of Port Arthur; St. Joseph's General Hospital
PORT COLBORNE — Port Colborne General Hospital
ST. CATHARINES — Hotel Dieu Hospital; Niagara Peninsula Sanatorium; The St. Catharines General Hospital
ST. THOMAS — St. Thomas-Elgin General Hospital
SARNIA — Sarnia General Hospital; St. Joseph's Hospital
SAULT STE. MARIE — Plummer Memorial Public Hospital
SIMCOE — Norfolk General Hospital
STRATFORD — Stratford General Hospital
SUDBURY — Sudbury-Algoma Sanatorium; Sudbury General Hospital of the Immaculate Heart of Mary; St. Joseph's Hospital
TIMMINS — St. Mary's Hospital
TORONTO
Baycrest Hospital
The Doctors Hospital
The Hospital for Sick Children
Humber Memorial Hospital
New Mount Sinai Hospital
Northwestern General Hospital
North York Branson Hospital
Queensway General Hospital
The Runnymede Hospital
St. Joseph's Hospital
St. Michael's Hospital
Scarborough General Hospital
Sunnybrook Hospital
The Toronto East General and Orthopaedic Hospital
Toronto General Hospital
Toronto Hospital for Treatment of Tuberculosis
The Toronto Western Hospital
Women's College Hospital
WALLACEBURG — Sydenham District Hospital
WELLAND — Welland County General Hospital
WINDSOR
Essex County Sanatorium
Grace Hospital
Hotel Dieu of St. Joseph
Metropolitan General Hospital
WOODSTOCK — Woodstock General Hospital

QUEBEC

ALMA — Hôtel-Dieu du Christ-Roi d'Alma
ARTHABASKA—Hôtel-Dieu d'Arthabaska
BEAUCEVILLE-OUEST — Hôpital Saint-Joseph
CHICOUTIMI — Hôtel-Dieu Saint-Vallier
DOLBEAU — Hôtel Dieu du Sacré-Coeur
DRUMMONDVILLE — Hôpital Ste-Croix

(concluded on page 74)



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1. Burnett, W. E.: *Program for Prevention & Eradication of Staphylococcic Infections*, J.A.M.A. 166: 1183-84 (March 8) 1958. 2. Adams, R.: *Prevention of Infections in Hospitals*, Am. J. Nurs. 58:344-48 (March 1958). 3. *Medical Authorities Recommend Ways to Control Infections*, Mod. Hospital 90: March 1958, 51-54.

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Accredited Hospitals

(concluded from page 70)

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GRAND'MERE — Hôpital Lafleche; The Laurentide Hospital
HAUTERIVE — Hôtel - Dieu de Hauterive
HULL — Hôpital du Sacré-Coeur
JOLIETTE — Hôpital Saint-Eusebe
JONQUIERE — Hôtel-Dieu Notre Dame de l'Assomption
LAC EDOUARD — Sanatorium du Lac Edouard
LAC ETCHEMIN — Sanatorium Begin
LEVIS — Hôtel-Dieu de Levis
LOUISEVILLE — Hôpital Comtois
MATANE — Hôpital du Très St-Redempteur
MONT JOLI — Sanatorium St-Georges
MONTMAGNY — Hôtel - Dieu de Montmagny

MONTREAL —

Alexandra Hospital
Catherine Booth Mother's Hospital
Doctors Hospital Incorporated
Grace Dart Hospital
Hôpital General de Verdun
Hôpital Maisonneuve
Hôpital Notre-Dame
Hôpital Notre-Dame-de-la-Merci
Hôpital Notre-Dame de l'Espérance
Hôpital Pasteur
Hôpital du Sacré-Coeur
Hôpital Ste-Jeanne D'Arc
Hôpital St-Joseph
Hôpital St-Joseph de Rosemont
Hôpital Ste-Justine
Hôtel-Dieu de Montréal
Institut de Cardiologie de Montréal
Jewish General Hospital
Jewish Hospital of Hope
Lachine General Hospital
Montreal Children's Hospital
Montreal General Hospital
Montreal Neurological Institute
The Queen Elizabeth Hospital of Montreal
Queen Mary Veterans' Hospital
Reddy Memorial Hospital
Royal Victoria Hospital
St. Mary's Memorial Hospital of Montreal
Shriners' Hospital for Crippled Children

NICOLET — Hôpital du Christ-Roi
NORANDA — Hôpital Youville
ORMSTORM — Barrie Memorial Hospital

QUEBEC —

Hôpital de la Misericorde
Hôpital de l'Enfant Jesus
Hôpital du Saint-Sacrement
Hôpital Saint-Francois d'Assises
Hôpital Saint-Michel-Archange
Hôpital Laval
Hôtel-Dieu de Québec
Jeffery Hale's Hospital
Ste. Foy Veterans' Hospital
RIMOUSKI — Hôpital Saint-Joseph
ROBERVAL — Hôtel-Dieu Saint-Michel
SHAWINIGAN FALLS — Hôpital Sainte-Therese; Joyce Memorial Hospital
SHERBROOKE — Hôpital General St-Vincent-de-Paul; Hôtel-Dieu de Sherbrooke; Sherbrooke Hospital
SOREL — Hôtel-Dieu de Sorel
STE-AGATHE DES MONTS — Mount Sinai Sanatorium; Royal Edward Laurentian Hospital
STE-ANNE DE BELLEVUE — Ste. Anne's Hospital
ST-HYACINTHE — Hôpital Saint-Charles
ST-GEORGES-OUEST — Hôtel-Dieu Notre-Dame de Beauce
ST-JEAN — Hôpital Saint-Jean
ST-JEROME — Hôtel-Dieu de Saint-Jerome
SWEETSBURG — Brome-Missisquoi-Perkins Hospital
THETFORD MINES — Hôpital Saint-Joseph
TROIS-RIVIERES — Hôpital Ste-Marie; Hôpital Saint-Joseph; Hôpital-Sanatorium Cooke
VALLEYFIELD — Hôtel Dieu de Valleyfield
VAL D'OR — Hôpital St-Sauveur

NEW BRUNSWICK

BATHURST — Hôtel-Dieu de Saint-Joseph; Notre-Dame de Lourdes Sanatorium
CAMPBELLTON — Hôtel-Dieu de St-Joseph; Restigouche and Bay Chaleur Soldiers' Memorial Hospital
CHATHAM — Hôtel Dieu of St. Joseph
DALHOUSIE — St. Joseph Hospital
EDMUNDSTON — Hôtel-Dieu de Saint-Joseph
FREDERICTON — The Victoria Public Hospital
MONCTON — Hôtel Dieu d'Assomption; The Moncton Hospital
PERTH — Hotel Dieu of St. Joseph
ST. BASILE — Sanatorium St. Joseph
SAINT JOHN —
Lancaster Hospital
Saint John General Hospital
Saint John Tuberculosis Hospital
St. Joseph's Hospital
SACKVILLE — Sackville Memorial Hospital
SUSSEX — Kings County Memorial Hospital
TRACADIE — Hôtel-Dieu de Saint-Joseph
WOODSTOCK — Carleton Memorial Hospital

NOVA SCOTIA

ANTIGONISH — St. Martha's Hospital
CORNWALLIS — R.C.N. Hospital
GLACE BAY — Glace Bay General Hospital; St. Joseph's Hospital
HALIFAX —
Camp Hill Hospital
The Children's Hospital
Grace Maternity Hospital
Halifax Infirmary
Halifax Health Centre, TB Division
Canadian Forces Hospital (Halifax)
Victoria General Hospital
KENTVILLE — Blanchard - Fraser Memorial Hospital; Nova Scotia Sanatorium
LIVERPOOL — Queens General Hospital
LUNENBURG—Fishermen's Memorial Hospital
NEW GLASGOW — Aberdeen Hospital
NEW WATERFORD — New Waterford General Hospital
NORTH SYDNEY — Saint Elizabeth Hospital
SHELBURNE — Roseway Hospital
SYDNEY — Point Edward Hospital; St. Rita Hospital; Sydney City Hospital
SYDNEY MINES — Harbour View Hospital
WINDSOR — Payzant Memorial Hospital
WOLFVILLE — Eastern Kings Memorial Hospital

PRINCE EDWARD ISLAND

CHARLOTTETOWN — Charlottetown Hospital; Prince Edward Island Hospital; Provincial Sanatorium
SUMMERSIDE — Prince County Hospital

NEWFOUNDLAND

CORNER BROOK — West Coast Sanatorium; Western Memorial Hospital
ST. ANTHONY — St. Anthony Hospital
ST. JOHN'S —
Grace Hospital
St. Clare's Mercy Hospital
St. John's General Hospital
St. John's Sanatorium

O.H.A. New Address

The Ontario Hospital Association and its Blue Cross Plan have moved to their new headquarters. The address is now: Flemingdon Park, Don Mills, Ont.

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Ask to be asked
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and debt financing as of January 1 of this year, Bill 2 excludes from the per diem payments to hospitals amounts for (1) the payment of any capital debt or interest thereon; (2) the payment of any debt incurred prior to January 1, 1961; (3) depreciation on the value of land, buildings or physical plant; and (4) the amount of interest or carrying charges.

While this problem of debt retirement varies from those who have no problem to those who are absolutely desperate, the total picture is of such grave importance that it demands a solution based not on expediency but on sound financial principles.

6. Hospitals should be provided with the means of financing future capital costs.

Comment: For those engaged or about to engage in new building or renovation this is a problem which must be faced just as soon as our daily operational pattern and a programming of existing debt retirement have been put on a sound basis.

7. The capital and income from endowments and trust funds and income received from sources other than on account of services to patients should be retained by the hospital.

Comment: With the exception of a few minor areas, such as telephone and television rental income, parking space rental income and others, this principle is safeguarded in Section V.p. of Schedule A of the regulations.

8. Hospitals should not be expected to guarantee, except in an emergency, that standard ward accommodation will be available above the predetermined allotment of standard ward beds based on authorized capacity.

9. The relationship now existing between the hospital and the doctor, the hospital and the patient, the doctor and the patient, as covered by the by-laws or rules and regulations of any given hospital, should not be disturbed.

Comment: This principle is basic to good hospital management and should be constantly observed by all.

10. The standards of patient care are of the utmost importance and should be safeguarded.

Comment: There must be no compromise in the maintenance and improvement of the best standards of patient care.

11. A scheme of hospital insurance should be administrated by a permanent hospital insurance commission.

Comment: The Q.H.A. is well aware of the different types of administration for hospital insurance plans but we prefer, and very strongly, that of a commission. The members of such a commission should consist of persons with experience in hospital administration, health practices, and problems. We cite the very successful experience of the commission form of administration in other provinces. We feel that the administration of our own hospital insurance program is so complex, (involving the expenditure of tens of millions of dollars annually) that the needs of all could best be met through the relative freedom of action inherent in a commission.

12. The Quebec Hospital Association should be consulted in the development of the administrative aspects of a hospital insurance scheme as they affect hospitals.

Comment: It is a matter of great disappointment that we have not had the honour of being consulted to the degree we had hoped and in fact we had a right to expect. It is true that we have met with the Premier, and with the Minister of Health, and on a number of occasions with the director of the plan, Dr. Jules Gilbert. We are most grateful to Dr. Gilbert for discussing with us in the frankest way the points we have presented. But I must add that these discussions have, in the main, been after decisions had been made; whereas we would have preferred consultation before final action was taken. I do not mean to imply that the association should have the right of veto over every directive that the insurance service might formulate; but I do say that there are many occasions when prior consultation with this association would be of the greatest help. Collectively, we have a wealth of experience in the management of hospitals which should be of benefit to the plan. We only ask that we be asked.

It is true that there is a consultative committee, with a very widely representative membership. This committee has met once. As a member, representing this association on the committee, I hope that meetings will be more frequent in the future and that the committee will be able to make a very real contribution to the consideration of policies and problems of the insurance service.

**The author acknowledged his indebtedness to his many colleagues who responded readily when he made his survey.—Edit.*

Experience to Date

On the basis of information received from various types of hospitals* to March 31 of this year, compared to the same period in 1960, there are very definite trends:

1. An increase in admissions from four to ten per cent; in some cases lower and in some cases higher.

2. An increase in the average length of stay per patient, the most common figure being one full day. There were a few instances of an actual decrease.

3. Much larger waiting lists and longer waiting periods for admission. Waiting lists have commonly increased from 75 to 100 per cent while the waiting period is commonly two to six weeks. There is, of course, wide variation in this period from hospital to hospital, and, indeed, in the same hospital, from one department to another. These waiting lists and waiting periods refer to elective admissions only. Emergencies are looked after at once. We should also remember that the winter months have always been very busy, with waiting periods of, not uncommonly, two to four weeks.

I well appreciate that the long waiting period is a source of annoyance and bewilderment to many patients and even more so in the case where a person booked for admission must be deferred from the appointed date for lack of beds. The following simple comparison may help to classify the hospitals' problems in this regard. Actually, it emphasizes the difference rather than the similarity. A hotel makes reservations for a well person for a specified period and the guest is accommodated on the appointed day and departs on the appointed day. If he wishes to stay longer, he may do so only if there is room available. Not so with the hospital. We book in advance with every intent to honour that commitment, and at the same time maintaining a reasonable number of beds for emergencies. However, we have no control over the number of emergencies which might come to our doors in any 24-hour period; and often the number exceeds that anticipated on the basis of experience. We must look after emergencies and if they fill our beds, then we have no recourse but to defer those booked for elective admission on that day. Certainly, no admitting officer likes to call a patient, who has already made various arrangements for admission, but we

Ask to be asked

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have no alternative. Another factor is that we cannot always gauge the date of discharge of any patient even though we try to keep our estimates conservative on the basis of experience.

4. There has been a definite increase in the number of laboratory tests (from three to ten per cent) and a number of hospitals quoted the figure of 20 per cent.

5. While observing strictly the requirement of 40 per cent of the beds kept for standard ward patients, the picture generally shows one of increased demand for private and semi-private accommodation.

What are some of the conclusions to be drawn from this survey?

1. With more admissions, hospitals are fuller than ever before, with average daily occupancy in the high nineties which puts an added strain on all members of the staff.

2. The increased length of stay requires the closest attention of the medical and administrative staffs of each hospital to see that there is no abuse of the insurance service. We must avoid any inclination of the patient to stay in hospital one day longer than is necessary. The medical profession must insist that in-patient care is for those who need it; it is not to be used as a matter of convenience. The most undesirable effect of this increased length of stay is an ever-increasing waiting list and waiting period, and in the long run it will mean that fewer patients will actually be admitted over any given period of time.

3. The greater demand for private and semi-private accommodation is not unexpected. Patients who formerly were on the ward now can use the money earlier required for care at the ward level to pay the differential for semi-private accommodation and their doctor's fees. Here again the picture varies widely from hospital to hospital, depending on the percentage of public patients admitted in 1960.

4. The marked increase in laboratory tests is cause for concern. Here the insurance service and hospital administration look to the attending doctors to see that only those tests which are absolutely necessary are prescribed. An increased number of tests mean more personnel and more space, both of which are costly.

5. Patient days of care have increased from five to nine per cent, with one figure of 14 and one of 20 per cent. This general increase, of course, means a much heavier burden on all those concerned with direct patient care and on the various service departments.

6. As of December 31, 1960, many hospitals had hundreds of thousands of dollars tied up in accounts receivable. These accounts were, and still are, the responsibility of the patient. The experience for the first three months of this year, generally speaking, is that the total has been cut in half, although most report that the rate of payment is slowing up. The first charge against the monies received thus has been the payment of expenses incurred during December. Once those commitments are met, the monies so received are used for working capital and debt retirement.

7. Experience with the collection of the differential payments for semi-private and private accommodation has, on the whole, been very satisfactory. You will readily understand the position of hospitals requesting that this differential be paid upon discharge so as to obviate the expense of billing. Since the total amount as a rule is not large, there is no great hardship to the patient in meeting the hospital's practice.

8. The semi-monthly payments by the Quebec Hospital Insurance Service to the individual hospital on the basis of the provisional per diem rate is adequate to meet operating expenses in only about 50 per cent of those surveyed. The others find it less than adequate—which means that an adjustment in the per diem rate is indicated when the budget is reviewed.

Long-Stay Patients

In one large general hospital, 11 per cent of the patients, excluding those in psychiatry, had been in hospital, as of March 31, more than 30 days, with 57 being in from 30 to 60 days and 18 from 61 to 89 days. On the assumption that this 11 per cent is a reasonable figure for general hospitals, it points immediately to a problem well recognized in the hospital field, namely the need for adequate facilities for the long-stay patient. There is urgent need for a comprehensive study of this problem. We must ascertain what are proper facilities for those with long-term illness (including the type of illness); what suitable facilities exist; and what facilities need to be provided. I have already indicated the demand on our general hospitals —with heavier patient loads and long waiting lists—and the natural inference might well be that we need more beds for the acutely ill. On the contrary, it would be folly to build more general beds, which are very expensive, before adequate facilities at a much lower cost are provided for the long-stay patient. The latter would free many beds in general hospitals for those actually in need of intensive treatment. The turn-over of beds in the acute general hospital average two and one half to three a month so that one patient in 60 days means that a bed is blocked for five patients with short-term illness. A comprehensive study would also include consideration of the need for adequate convalescent facilities. The chief of a medical service in one of our large hospitals told me that 13 of his 44 patients or 30 per cent, could and should be in proper facilities for the convalescent or long-stay patient, but that there were no such facilities available.

The University Hospital

The general practitioner is the very foundation of medical care in this country, yet there is room and need for the specialist in the management of patients who present particular problems. Similarly, a small community hospital has a very definite place in our way of life. I have some appreciation of their worth because I was on the staff of one for some six years. The small hospital, admirable as it is, cannot and should not be expected to meet all the needs of the community, hence the large university hospital has a special rôle. Its staff, because of their ability and long and arduous years of training and experience, are necessary in the treatment of cases beyond the capabilities of the general practitioner. In addition to patient care, the university hospital has very heavy responsibilities in post-graduate and undergraduate teaching of interns, residents, medical students, nurses, dietetic interns, and many others. The trainee of today is the staff member of tomorrow. Moreover, university hospitals have a responsibility in furthering the search for new knowledge.

Since the responsibilities of the university hospital are so great in many areas, it follows that their operating expenses are much higher than for other hospitals.

I mention these facts because it is important that those administer-

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ing a program of hospital insurance be well aware of the exact state of affairs in university hospitals which are deserving of special consideration. They are at the very roots of medical education and progress. In passing, I would like to refer you to an article, "Medical School and Teaching Hospital" by Dr. J. A. MacFarlane, Dean of Medicine of the University of Toronto, which appeared in the April 1 issue of the *Canadian Medical Association Journal*. Dr. MacFarlane points out, amongst other things, the need for the fullest recognition of the out-patient department as the basic teaching facility, and makes a plea that the order of things be changed so that the out-patient department no longer continues to be a tremendous financial burden to the hospital.

As we look back over these past three months we cannot but feel that a more vigorous publicity campaign would have helped. Informative pamphlets should have flooded every conceivable place. Because the residents of this province were not adequately informed, it fell to the staffs of the hospitals, particularly those concerned with admitting, to spend an unusually large part of their time in answering queries on many details of the plan. I would suggest to the officials of the Quebec Hospital Insurance Service that there is still considerable room for publicity, and that it would be in the best interests of the plan to have the publicity campaign stepped up considerably.

Coming Events

June 5-29—Hospital Organization and Management Summer Session, Winnipeg, Man.

June 19-23—Canadian Medical Association, 94th Annual Meeting, Queen Elizabeth Hotel, Montreal, P.Q.

June 20-21—Catholic Hospital Conference of Saskatchewan Annual Convention, Saskatoon, Sask.

June 20-23—Western Canada Institute, Saskatoon, Sask.

June 23-29—Third International Convention of X-ray Technicians, C.S.R.T. and A.S.X.T., Queen Elizabeth Hotel, Montreal, P.Q.

June 25-July 21—Fourth Annual Hospital Administrators' Development Program, sponsored by The Sloan Institute of Hospital Administrators, Cornell University, Ithaca, N.Y.

June 26-28—Comité des Hôpitaux du Québec Convention, Montreal Show Mart Inc., Montreal, P.Q.

Sept. 10-14—International Tuberculosis Conference, Royal York Hotel, Toronto, Ont.

Sept. 11-13—Canadian Association of Medical Record Librarians Annual Meeting, Ottawa General Hospital and St. Vincent Hospital, Ottawa.

Sept. 11-12—O.H.A. Institute on Public Relations, O.H.A. headquarters, Toronto, Ont.

Sept. 24—Convocation Ceremony, A.C.H.A., Convention Hall, Atlantic City, N.J.

Sept. 25-28—American Hospital Association, Atlantic City, N.J.

Oct. 1-2—The Catholic Conference of Manitoba, Marlborough Hotel, Winnipeg, Man.

Oct. 3-5—Manitoba Hospital and Nursing Conference, Royal Alexandra Hotel, Winnipeg, Man.

Oct. 5-6—Saskatchewan Hospital Association Annual Meeting, Saskatchewan Hotel, Regina, Sask.

Oct. 8-9—Catholic Hospital Conference of Alberta, Calgary, Alta.

Oct. 10-12—Associated Hospitals of Alberta Convention, Calgary, Alta.

Oct. 15-16—Catholic Hospital Conference of British Columbia Annual Convention, St. Vincent's Hospital, Vancouver.

Oct. 17-19—British Columbia Hospitals' Association Convention, Hotel Vancouver, Vancouver, B.C.

Oct. 23-25—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.

Physician Specialists

The Q.H.A. membership is very concerned about the insurance service directive placing a ceiling on shareable costs of the salaries of physician specialists engaged in diagnostic services in the hospital. We feel that this is contrary to the spirit of Bill 320 and indeed of Bill 2. It is of no consolation to say that hospitals may pay in excess of the ceiling, for hospitals have no income, generally speaking, in excess of their per diem allowance. We are concerned that we shall be placed in a most disadvantageous position compared to our neighbouring provinces, and that as a result we will lose present specialists and fail to attract any in the future. Such a state of affairs could only have a most deleterious effect on medical care. We urge, therefore, immediate and more favourable consideration of this directive.

We welcome Premier Lesage's invitation to assist in the drafting of a Public Hospitals Act. We are most grateful to him for the lead he has taken, and we of the Q.H.A. promise to give our immediate attention to this task.

Necessary Nursing Service

I am as disturbed as Dr. Jules Gilbert to learn from him of the instance of abuse of the benefit, necessary nursing service. It can and must be controlled. A number of hospitals are using to advantage two forms, as a control—one signed by the attending doctor and the director of nursing where a private duty nurse is required over and above the regular nursing service, and a second which the patient signs acknowledging his responsibility to pay. Either one of these forms must be signed before or at the time the private duty nurse is engaged.

Budgets

I would impress on the director of the Quebec Hospital Insurance Service the absolute necessity to return to hospitals their approved budgets at the earliest possible date. Otherwise the hospitals are deprived of their financial blue prints and a very large measure of budget control is lost.

There is no doubt that the insurance plan is of the utmost benefit to the residents of this province. We appreciate that there have been many problems; we of the Quebec Hospital Association offer our co-operation; indeed we ask that we be asked to assist in the solution of these problems! ■

Hospital Expansion
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gram than for the establishment of a new hospital. The medical and surgical units seem able to offer the best service to the community if they operate at 75 per cent occupancy over the year in a small hospital (say, under 50 beds), 80 per cent in a medium-sized hospital (say, 50 to 200 beds), and at 85 per cent in larger institutions. This provides an economical level for income and staffing purposes, but is low enough to take care of the peak occupancy periods (usually in the winter months) and to provide the required emergency beds. The obstetrical and paediatric units, however, cannot operate above 65 per cent occupancy over the year in any size of hospital without feeling severe strains from overcrowding at times; the very wide fluctuations in demand for these beds are well known.

If you take the number of patient days for each of these services in your last two years of operation, it is easy to determine how many beds each would have required to operate at the ideal level of occupancy. Now, add the number of beds to determine how many you should have had last year. Throw in the population percentage increase for the next five to ten years, as determined by your study. Sprinkle lightly to account for an increase in the number of doctors expected to settle in your community. Cook slowly for three years to account for buck passing, fund raising, planning and construction and you may just have enough hospital beds to let you relax for five years. Then it may well be time to start the process all over again.

The "bed - ratio - to - population basis" has become complicated by a plethora of differing formulae in different parts of the country. One of the beauties of the British North America Act is that it gave us an excuse, in health matters, to argue ten different ways on any one subject.

British Columbia, for instance, does not have a fixed ratio, but uses 5.5 beds per 1,000 population as a guide for active treatment purposes; the ratio for an individual area, when many factors are taken into consideration, has varied from 4.5 to 6.5 beds for this type of patient. The activation program (rehabilitation, chronic treatment and convalescent care) was using the guide of 1.0 beds per 1,000 population, but is undergoing further consideration, as being somewhat liberal. There is no hospital provision under the title of what we loosely call the chronically ill; the policy has been to have those who can benefit from rehabilitation admitted to a hospital for that purpose, and to offer support to the construction of nursing homes for long-term care of others usually grouped in this nomenclature. An estimate of 2.0 beds per 1,000 population has been used for nursing home patients.

Alberta has based its ratio system on a requirement of 7.5 active treatment beds per 1,000 population, of which 8 to 10 beds per 1,000 is allocated to large urban or regional general hospitals, with 5 beds per 1,000 for rural community hospitals. The extensive program recently announced for care of the chronically ill is based on 2.5 such beds per 1,000 population. The year 1966 is currently in use as the basis for the population determination.

Saskatchewan has the longest experience in the provision of hospital care under a government-sponsored insurance plan, and the officers still profess to be content with the ratio, established many years ago of 7.5 active treatment beds per 1,000 population. Although 30 per cent of the hospital days in Saskatchewan are considered to be used for the chronically ill, there is no separate or specific bed ratio assigned for this type of patient. A health survey now under way is using population projections for 1971 as a basis for its recommendations.

Manitoba froze all new construction planning while awaiting the results of a major survey which has just been completed and reported. No set ratio was used in determining the requirements for active treatment beds, although a ratio of slightly over 1.0 beds per 1,000 acted as a guide in making the recommendations for beds for rehabilitation purposes and the chronically ill. The province was divided into several districts and each was studied, on its own merits, in order to assess the needs up to 1966.

Ontario uses a guide, for active treatment beds, of 4.0 beds per 1,000 population (in the year 1966) for community hospitals. Those centres which do a greater amount of referred and specialized work are called district hospitals and get an additional 0.5 beds per 1,000 population for the area. Certain large cities, with extensive specialized facilities and a wide range of medical specialists, are considered as regional hospital centres and the province is divided among them on the basis of another 0.5 beds per 1,000 population. This gives a total of 5.0 beds per 1,000. For the chronically ill, a ratio of 1.0 beds per 1,000 is used with an adjustment upward or downward for the percentage of persons over the age of 64 as compared with the over-all provincial average.

To my knowledge, the Quebec Government has not used a specific over-all ratio as a determinant in approving hospital projects, but is now considering such a basis.

Prince Edward Island recommends a figure of 5.5 beds per 1,000 population for active treatment beds, and 1.5 beds for the chronically ill. The bed needs were determined for each centre, however, from a survey which studied each hospital on its own merits, and the recommended number of beds divided into the population prediction happened to approximate 5.5 and 1.5.

New Brunswick is still experimenting with a formula, but is using a minimum standard in its recommendations of 4.5 hospital beds per 1,000 population for a district or community hospital. The regional hospital will have this ratio plus another 1.0 beds per 1,000 for the region but outside the immediate area of the hospital. Base hospitals will be encouraged to provide 5.5 beds per 1,000 population in their area plus another 1.0 bed per 1,000 of the more distant population. This makes a total ratio of 6.5 beds per 1,000 population as a minimum standard. It is hoped that long-stay patients will receive care either in "specialized facilities" in regional and base hospitals for rehabilitation, or otherwise as a separate program to be worked out with welfare authorities.

Nova Scotia has been following a guide outlined in a report on their needs which was published in 1957. This called for an over-all ratio for all hospitals (excluding mentally ill and tuberculosis, as do all these formulae) of 7.5 beds per 1,000 population. This is based on 5.5 beds for active treatment and 1.4 beds for the chronically ill, plus a ratio of 0.3 for the province to handle the treatment of veterans in hospitals of the Department of Veterans' Affairs.

Newfoundland has only 4.0 active

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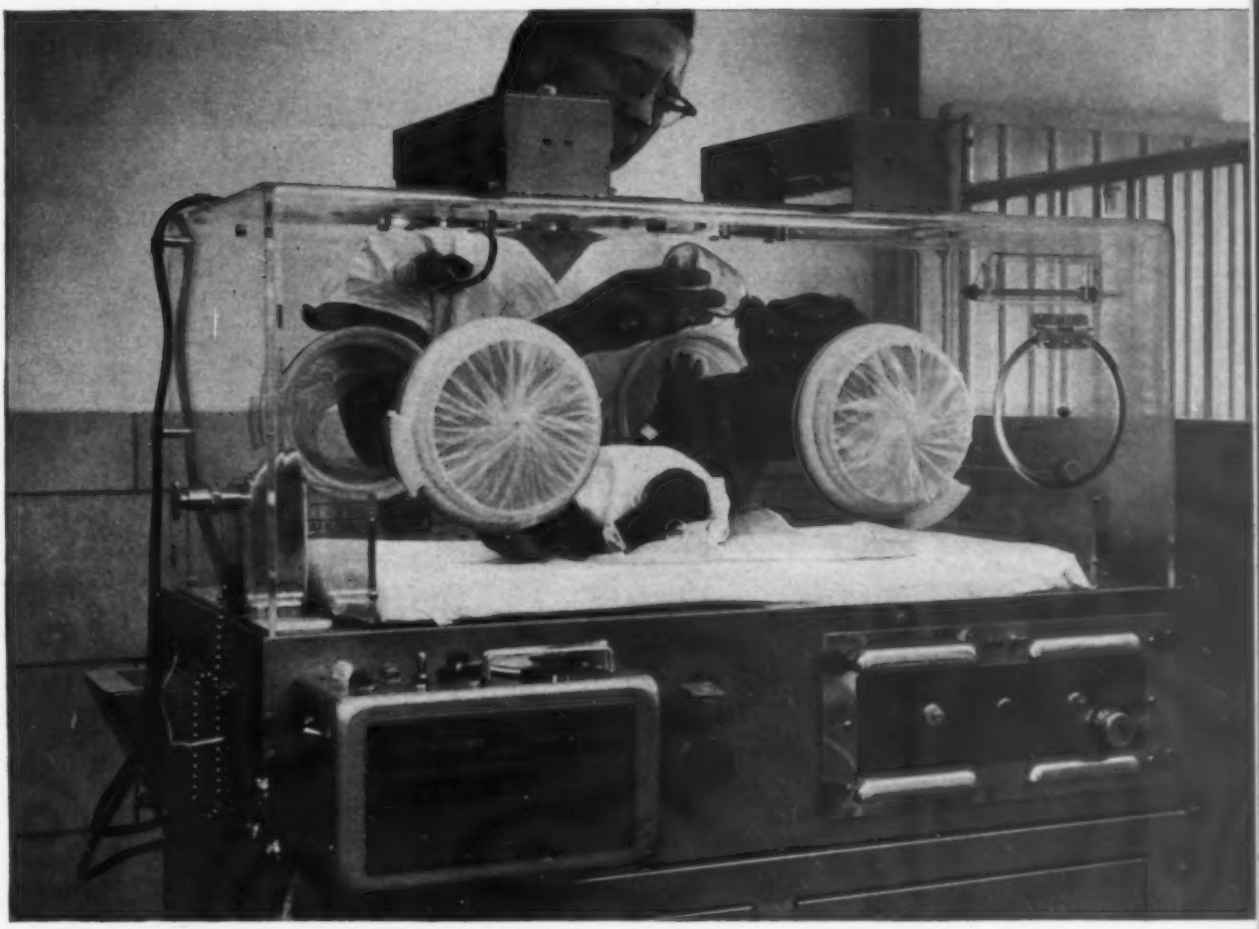

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Hospital Expansion

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treatment beds per 1,000 population at present; but the Department of Health is setting its sight on enough beds to give a ratio of 6.0 for active treatment and 1.0 for the chronically ill per 1,000 population. It is using 1968 as the basis for planning, plus such other factors as age groups, population increase and decrease in certain locations, road building plans, availability of specialized services, et cetera.

In fact, it would be unfair to suggest that any province uses its formula without taking a considerable number of factors into consideration. As an example, Saskatchewan has a complicated formula which calculates the 7.5 beds per 1,000 population, but adjusted for the average length of stay for that particular size of hospital, the proportion of rural and urban dwellers served, and the number of non-beneficiaries of the plan (usually tourists) cared for in that area. These ratios are always subject to alteration as more experience is gained in gauging requirements in each province.

In the United States, the Public Health Service Act and its regulations set up a limitation beyond which federal funds will not be provided for construction programs. This is set at 4.5 beds per 1,000 population for active treatment with somewhat higher ratios in the less densely populated states, and 2.0 beds per 1,000 for the chronically ill. These ratios are meant to be standards for determining the number of beds needed to provide adequate hospital and nursing home care to the people of an entire state. The state itself is allowed considerable latitude in the distribution of these beds.

This lengthy summary of the ratio method indicates, if nothing else, that there is no one answer to the question "When is hospital expansion needed?" It sounds like a flippant answer to say "It all depends on where you happen to live", but this is, in fact, very true. Hospital-going habits vary widely from community to community, as we saw quite clearly in our examples of hospitals "A" and "B" at the beginning of this paper. It is unwise to use the criteria of one area in estimating the needs elsewhere. This also applies to many other aspects of the hospital, other than total bed determination. For example, the city of Hamilton has 52 per cent more hospital beds than the city of Saskatoon, yet within that total, Hamilton has 129 per cent more maternity beds than does Saskatoon. The answer in this case is an easy one. Hamilton serves a densely populated urban area, whereas Saskatoon serves a large region, much of which is well provided with beds for obstetrical care, but not for the specialized referral work offered only in the city itself.

In determining expansion requirements, there is no substitute for a thorough survey at the local level rather than the use of formulae imposed from above. One is a ready-made garment and the other is tailor-made; it may fit you very well or it may be baggy in places and tight in others. The best answer is, I believe, a four-stage process:

1. Get your house in order and co-operate with other such agencies in the community to make certain that you are making the best and fullest use of the hospital for its intended purpose. An honest appraisal of the factors involved in such a study may offset the demand for an expansion program.

2. Undertake a community survey, or have it done for you, and project the findings in relation to the ideal occupancy levels for your various services. This should indicate the number of beds you will require at the projected date, but in relation to the standard of service you now provide.

3. Since you will have to do it anyway, apply the ratio system in use in your province to the population estimate at least five years in the future, and divide the figure obtained in an equitable fashion among all the hospitals in your community, if this is applicable. In about 50 per cent of the cases tried, the occupancy method and the ratio method will be in agreement. Where they do not agree, there are a great number of factors usually employed in reconciling them.

4. Have an experienced hospital planner help you study the departmental needs with recommendations from the department heads themselves. Existing space may be used to better advantage. After thorough analysis, it may be necessary to undertake only a very limited expansion program. In some cases, of course, it will have to be a major one or total replacement of your present facilities.

After you have taken these steps, you should have the satisfaction of knowing that your hospital has made at least a temporary stop-gap in the actual need, if not the demand, for adequate hospital facilities for the citizens it serves. ■

Twenty Years Ago

From Canadian Hospital

June, 1940

Another Aspect of the Blockade

The price of fruit and vegetables has always been higher in England than the corresponding Canadian and American prices, but a press report from London dated May 10 gives prices which would make any Canadian dietitian tear her hair. Strawberries are priced at 20 cents *each*—which, we imagine, puts the favourite dish of "strawberries with clotted Devonshire cream" well beyond the pocket of most Englishmen. Cucumbers are 50 cents each, tomatoes 30 cents each, lettuce 20 cents a small head and mushrooms 60 cents a pound.

Tea for All at the Buffalo General Hospital

At the Buffalo General Hospital, staff, patients and their visitors are invited to "drop in for a cup of tea" between four and five o'clock on week days. Tea and cookies are served in the solarium and sometimes there's music from the organ played by one of the personnel.

The administrator, Dr. Fraser D. Mooney, says that they "wouldn't think" of discontinuing this pleasant practice. After a year and a half the administration believes that this afternoon pick-up adds considerably to the efficiency of the staff and that it's a strong point in a public relations program.

Hospital Plan Sets Record Enrolment

The largest single enrolment in the history of hospital and medical pre-payment care plans is now under way in Detroit at the Chrysler Corporation and Briggs Manufacturing Company.

The plans, which provide for complete hospital and surgical care, are being made available to 300,000 employees and their families through the corporations. The two service plans, hospital and medical, are now protecting more than 350,000 people throughout the state against the unpredictable hazards of hospital and medical care costs, it was reported.

books received

PSYCHIATRIC SERVICES AND ARCHITECTURE by A. Baker, R. Llewelyn Davies, and P. Sivadon. Published by the World Health Organization, Geneva, 1959. Illus. Pp. 58.

This booklet, the first in a series of public health papers published by the World Health Organization, was prepared by three W.H.O. consultants — two psychiatricts and an architect — who spent some time in Geneva during 1957 in collaboration with the mental health section personnel of the organization.

The purpose of the study was to re-examine the principles which should govern the architecture of psychiatric hospitals as set out by a W.H.O. Expert Committee on Mental Health which met in 1952, and to bring the subsequent report to the attention of all authorities responsible for the planning and management of mental hospitals.

In working out the organizational and architectural requirements the authors studied not only the planning and management of psychiatric hospitals, but also the structure and function of other psychiatric services such as outpatient departments, rehabilitation facilities, and other mental services. The first draft of this paper was circulated among members of the expert advisory panel on mental health, and an additional group of 29 psychiatrists from 13 countries and four architects from three countries. Their suggestions were taken into account during the writing of the final draft.

BECOMING A NURSE by Aileen D. Ross. Published by Macmillan of Canada, Toronto, Ont., 1961. Pp. 406. Price $5.00.

This sociological enquiry of the nursing profession is based on term papers written by Canadian nursing students for an introductory course in sociology given by the author over an eleven-year period.

The book analyzes the various aspects of a nurse's training, with special emphasis on the new problems facing nurses in these days of great technical and organizational changes. In many cases the nurses' opinions and reactions are given in their own words in quotations from the test papers.

The study gives an insight into the profession of nursing and the young women who are its members. In this way it will be of interest to those nurses who wish to assess their own training programs.

CANADA YEAR BOOK 1960. Published by the Dominion Bureau of Statistics, Ottawa, 1960. Illus. Pp. 1304. Price $5 for cloth-bound, $3 for paper-bound.

The 1960 edition of the Canada Year Book continues a series of annual publications giving official statistical and other information on almost every measurable phase of Canada's development.

Special feature articles are presented in each edition of the Year Book. Among those in the current issue is "Hospital Services and Hospital Insurance in Canada". Extensive revisions have been made in the textual and statistical material of the various chapters, and some new features have been added.

The Year Book is available from the Publications Branch, Department of Public Printing and Stationery, Ottawa, or from the Information Services Division, Dominion Bureau of Statistics, Ottawa, or from local bookstores across the nation.

TOXICITY OF INDUSTRIAL METALS by Ethel Browning, M.D. Published by Butterworth & Co. (Canada) Ltd., Toronto, Ont., 1961. Pp. 325. Price $10.00.

The development of the metal industry has brought with it the problem of health hazards for those engaged in it. This book gives a survey of the main features of the occurrence, preparation, physical and chemical properties, metabolism, and toxicology of the principal metals encountered in modern industry with a view to the prevention of toxic effects in the workers. A secondary purpose of the book is a general description of the radioactive form which some of these metals may take from nuclear fall-out. This survey, and particularly the bibliography, will be of value to biochemists.

NURSING TEAM LEADERSHIP by Thora Kron, R.N., B.S. Published by W. B. Saunders Co., Philadelphia, 1961. Illus. Pp. 163. Price $2.75.

The purpose of this book is to fill the need for a guide to the development of leadership in team nursing. Today good human relations and the development of leadership qualities are of prime importance because the rôle of the nurse is changing from that of giving care to one of directing and supervising the care given by others. Nursing leaders are also required in the fields of education and administration.

The author describes techniques which the nurse may use in planning, supervising, and evaluating the work of her team. Study questions appear at the end of each chapter. The book will be of interest to nursing students and graduates who need a guide to help them increase their effectiveness in team leadership. Other professional nurses should find it valuable for review.

CARDIO-VASCULAR SURGERY by the members of the surgical staff and members of the nursing service staff, the Methodist Hospital, Texas Medical Centre, Houston. Edited by George H. Peddie, M.D. and Frances E. Brush, R.N. Published by G. P. Putnam's Sons, New York, N.Y., 1961. Canadian publishers The Macmillan Company of Canada Ltd. Illus. Pp. 166.

Much of the material in this book is presented specifically for the nurse caring for cardio-vascular patients. The advances in cardio-vascular surgery have led to the creation of a new specialty in the field of nursing because the dangers and emotional trauma which patients undergo necessitate special nursing care.

This manual discusses the anatomy, physiology, pathology, diagnostic tests, anesthesia, and both pre-operative and post-operative care of the patient. With the aid of illustrations, surgical procedures are explained in detail in the belief that the more knowledge the nurse has of her patient's condition, the better care she will be able to provide for him.

IMPRESSIONS OF EUROPEAN PSYCHIATRY by Walter E. Barton, M.D., Malcolm J. Farrell, M.D., Frances T Lenehan, R.N., and William F. McLaughlin, M.D. Published by the American Psychiatric Association, Washington, D.C., 1961. Pp. 125.

This is a report by a team of

(concluded on page 109)

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Suds

(concluded from page 64)

may be washed at high temperatures — 130 to 140 degrees F. in order to remove the soil more effectively. It is a good plan to keep a row of bottles or jars to collect samples of each suds. This will show the dirt present in each suds water and the rate at which the dirt is being removed. It will also help to determine the number of suds required and for the classification of work being checked out.

Dirt which has been ground into the fabric responds best to higher than normal washing temperatures. If there is difficulty with ground-in soil, raise at least one of the suds operations, preferably the one just before the bleach, to approximately 190 to 200 degrees F. This particular operation should be run for at least ten minutes. Such an operation will do much to get rid of this heavy soil.

A question which often arises when formulae are discussed is, "How short is a short formula?" Now the idea of short washing formulae is not new. The best advice that can be given is that every plant should set up formulae that will wash its type of work in the shortest possible time. The length of a formula depends on many things, such as: (a) condition of the equipment; (b) amount and temperature of hot water; (c) degree of soil in the work; (d) control exercised on the washfloor; and (e) supplies and usage.

No two laundries are exactly alike. Thus, through experience and test, each plant should set up formulae that meet its conditions and do a quality job in the shortest time. These are the short formulae for that particular plant.

We just mentioned that the number of suds depends primarily on the degree or amount of soil present in the clothes being laundered. The same general idea holds true for the length of time the suds baths should be run. Formulae are normally based on ten-minute suds periods. This time interval is convenient and may be taken as a standard in the majority of cases. There will be times, however, depending upon conditions in the plant, when it is possible to reduce this time interval from ten to seven and sometimes even to five minutes. This is particularly true in the case of plants equipped with good machinery, good consistent water pressure, and large water inlets and outlets.

The fourth and final fundamental of good washing is the use of enough good, properly built soap. There is no doubt that laundries can use soap and alkali in many different combinations and still do a passable job of getting dirt out of the clothes. However, best results are obtained when the soap is properly built with alkali.

Alkali is essential in the washing process. It increases dirt removal and reduces washing costs. It is a mistaken impression, however, that because a little alkali is good, the more alkali used, the better the results. After a soap has been properly built in accordance with general standards, it is wasteful to use additional alkali. This principle holds true for any supply, soap, bleach, et cetera. ■

Safety Award:

first in Canada, second in U.S.

The Hon. Gordon Churchill presenting the award to Dr. I. Sutton.

Deer Lodge Hospital, Winnipeg, Man., won first place in the 1960 Government of Canada Fire Prevention Contest and received the C.A. Thomson shield. The Deer Lodge hospital was first among 93 other competing federal government hospitals in Canada. In receiving the plaque from the Rt. Hon. Gordon Churchill, Minister of Veterans Affairs, Dr. I. Sutton, superintendent of the hospital, indicated that success was due to total participation of all elements of the hospital staff and particularly, the strong leadership of the fire prevention officer, Roy B. Paul.

In the International Competition of the National Fire Protection Association, Deer Lodge placed second among 422 Canadian and American hospitals. First honorable mention went to Westminster Hospital in London, Ont., and fourth honorable mention to Sunnybrook Hospital in Toronto.

Awards in these contests are based on the whole year's activities, culminating in the Fire Prevention Week in October.

Cardiac Arrest Chart

The National Heart Foundation of Canada has recently published a Cardiac Arrest Chart with the aid of which the Foundation hopes more lives can be saved.

Detailed concise instructions for immediate action in heart stoppage are listed in sequence in clear, easily read type under a plasticized, transparent, washable finish. Directed to the surgeon, anaesthetist and nurse, the chart was prepared for the Foundation by Dr. R. O. Heimbecker, kell-known cardiac surgeon at the Toronto General Hospital. It is being distributed to all the larger hospitals in Canada as one of the Foundation's public services.

$12,500 Cheque Presented for Physiotherapy Unit

The presentation of $12,500 was made to the Assiniboine Hospital, Brandon, Man. The money will be added to the physical and occupational therapy building fund of the hospital. The cheque was presented by the Associated Canadian Travellers of Brandon. This is the A.C.T.'s third contribution to the building fund and brings the total amount of money donated by the club for this purpose to $36,500. Altogether the Brandon A.C.T. has pledged $85,000 towards the cost of the newly opened unit.

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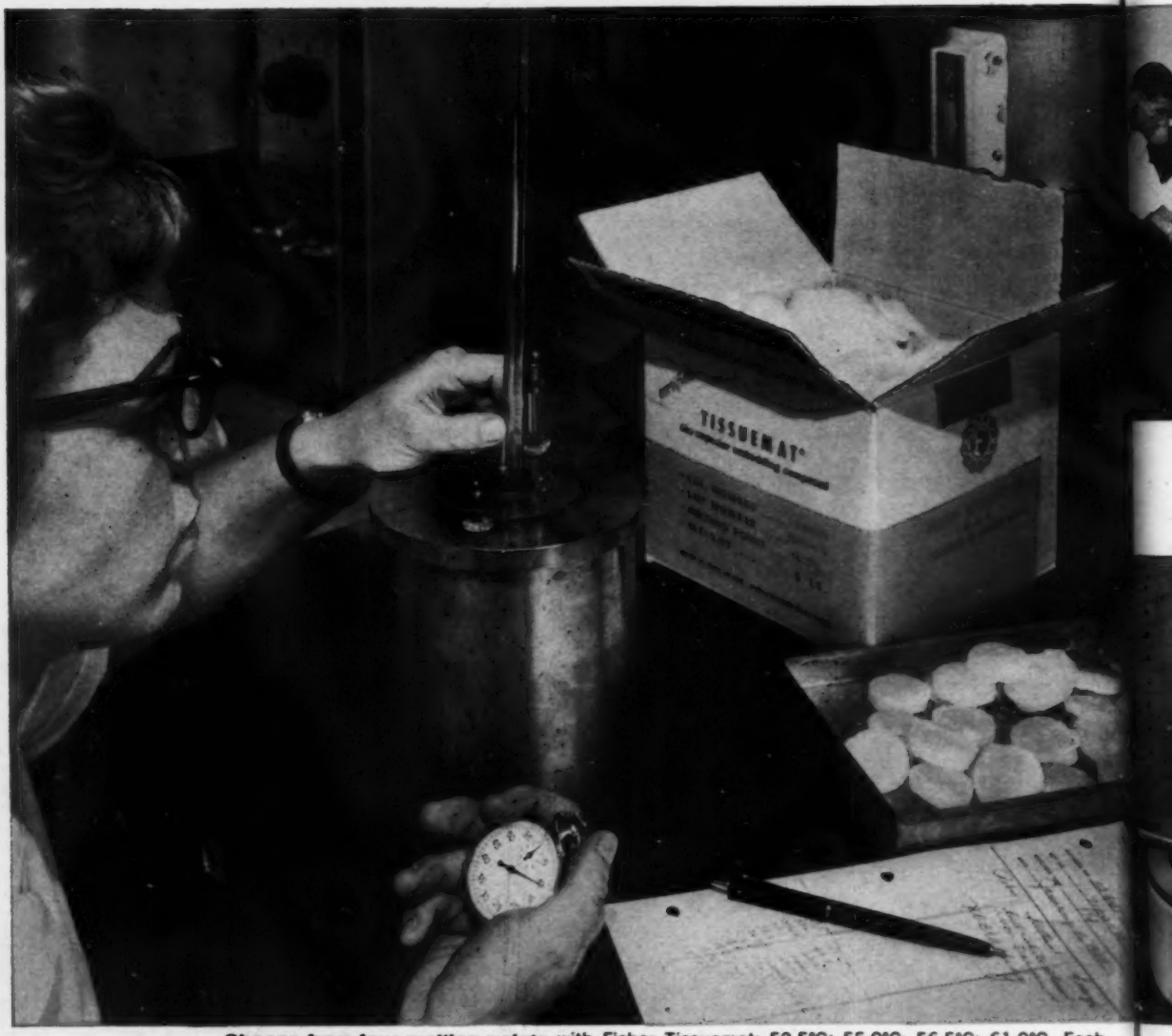

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(continued from page 58)

Spring hats were gay at the luncheon held by the Women's Hospital Auxiliaries.

sideration from the first day a patient is admitted to hospital. The physician must decide what care is necessary, and the social worker has a vital rôle to play in arranging that type of care for the patient, he concluded.

Mrs. B. S. Johnston, who is assistant director, medical social service department, at Montreal Children's Hospital, spoke of the rôle of the social worker in assisting people to accept their limitations. Inability to carry on usual activities is upsetting to the patient and his family, she said. Moreover, if a disability is ignored, it is often aggravated. In Montreal, she pointed out, patients get the best of care when acutely ill but if they have no homes to go to, the picture is grim. General hospitals are filled to capacity and those which used to accept some long-term patients are not allowed to do so under the insurance plan. The provision of a variety of services is a challenge which the community must face, and without delay, the speaker said.

Brigadier N. Jolly and Brigadier C. Lancaster, both of Catherine Booth Hospital, Montreal.

A speaker from the School of Social Service, University of Montreal, Mlle Jeanne Fortin, stressed the reorganization of family life that is required when a handicapped person returns home. Illness can create tension and cause financial difficulties. The social worker must assist all members of the family to adjust to the new situation. Often, of course, there is overcrowding and, if the family cannot cope, then the public must. She mentioned a number of public and private agencies which help, but such services must be coordinated, she said. Hitherto, Mlle Fortin continued, we have given most of our attention to diseases. People, as such, should now be a prime concern.

Mrs. D. I. Small of the Victorian Order of Nurses reported that long-term patients are now receiving the lion's share of that service. In the past year 84.1 per cent of calls were to help such patients, many of whom were referrals from hospitals. She pleaded for more organized home-care programs.

In the discussion period Dr. Bayne emphasized that every physician in the general hospital must learn to think in terms of the patient's future. There must be teamwork between the medical staff, the social service department and outside agencies. A speaker from the floor expressed the view that administrators of general hospitals are in a strong position to lead a movement for the development of rehabilitation centres and home-care plans.

Other Topics

Prof. Paul A. Crépeau of the Faculty of Law, McGill University, addressed delegates on the subject, "hospitals, doctors, nurses —and the law." Under this heading he discussed the importance of records, secrecy, comfort and care, safe equipment, narcotics, diagnostic services, well-qualified staff and professional controls over the practice of medicine. Space does not permit a report of this excellent presentation but we hope to publish the full text later. One interesting point must be noted. In the province of Quebec a patient can sue a hospital or doctor any time for a period of 30 years.

Because, at times, several meetings were held simultaneously, they cannot all be touched upon here. The comprehensive program included a problem clinic on maintenance, engineering and security; a joint meeting of dietitians, purchasing agents, accountants and controllers; a session on personnel problems under hospital insurance; and pharmacy under hospital insurance.

Resolutions Adopted

The Assembly adopted a resolution expressing thanks and appreciation to His Eminence Cardinal Léger; the Hon. Jean Lesage, Prime Minister of the province; and the Hon. Alphonse Couturier, Minister of Health, for their participation and interest. Two more resolutions expressed appreciation to members of the press and radio, the program committee, the exhibit committee, the

exhibitors themselves, and all the speakers and panel members at the convention.

Further resolutions read as follows. Be it resolved

- That appreciation be expressed to the Minister of Health of Quebec for the time given by Dr. Jules Gilbert, Director of Hospital Insurance, and Jean-Paul Marcoux.
- That thanks be given to past-president Dr. Paul Bourgeois, the executive officers, and board members for their leadership during the past year.
- That the association appoint a committee to undertake a study of hospital debts.
- That a study of the utilization of beds in the hospitals of the province be carried out with a view to more effective use for acute, convalescent and long-term care.
- That the government assure the necessary funds for the provision of an acceptable standard of service to the patients of those hospitals (mainly for tuberculosis and mental illness) which are in a critical financial position.
- That a symposium be organized as soon as possible for hospital trustees and board members.
- That the executive committee appoint, at the earliest possible date, a special committee to study and make recommendations regarding legislation concerning hospitals, and that the association co-operate in every way with the authorities in the development of such legislation.

Commenting on the final resolution, Dr. J. Gilbert Turner, president, said: "This is our acceptance of Premier Lesage's invitation to advise him." ■

Medical Research Council Established

A Medical Research Council has been established to expand the federal government's rôle in medical research. Dr. Ray F. Farquharson, professor emeritus of medicine at the University of Toronto, has been named the council's first chairman.

The new council will function under the administration of the National Research Council, but will have virtually complete autonomy. It will take over the functions of the N.R.C. Division of Medical Research which distributes grants and fellowships to stimulate medical research.

A.C.H.A. Activities

Election of Regents

Nominations of candidates for the Board of Regents, the College's governing body, are being sought from the membership of the society in special preliminary ballots which have been sent out.

Vacancies exist in six of the College's 18 regions: 3, 6, 9, 12, 13, 16. One of them, region 16, embraces the provinces of Alberta, British Columbia, Manitoba, Saskatchewan, the Northwest Territories, and the Yukon Territory. The current regent of region 16, eligible for re-election, is Donald R. Easton, M.D., superintendent of the Royal Alexandra Hospital in Edmonton.

Also eligible for re-election are present regents Delbert L. Price, administrator of the Children's Memorial Hospital, Chicago, Ill. (region 9); Boone Powell, administrator of Baylor University Medical Centre, Dallas (region 12); and Roy R. Anderson, superintendent of Presbyterian Hospital, Denver (region 13).

Two regents, Clyde L. Sibley, administrator of Birmingham Baptist Hospital, Birmingham, Ala. (region 6) and Harold T. Prenzel, administrator of Montgomery Hospital, Norristown, Pa. (region 3) are ineligible for re-election according to the society's by-laws because they have completed two successive terms of service as regents.

To qualify for the office of regent, a person must be a Fellow in the College and be an administrator or assistant administrator of an approved hospital in the region where the office is available.

Preceptors Conference

The date of the Midwestern Preceptors Conference, originally scheduled for May 18 to 19 in St. Louis, Mo., has been advanced to August 14-15 at the A.H.A. headquarters in Chicago. The conference will be held concurrently with the 12th Chicago Advanced Institute for Hospital Administrators to be held August 14-18.

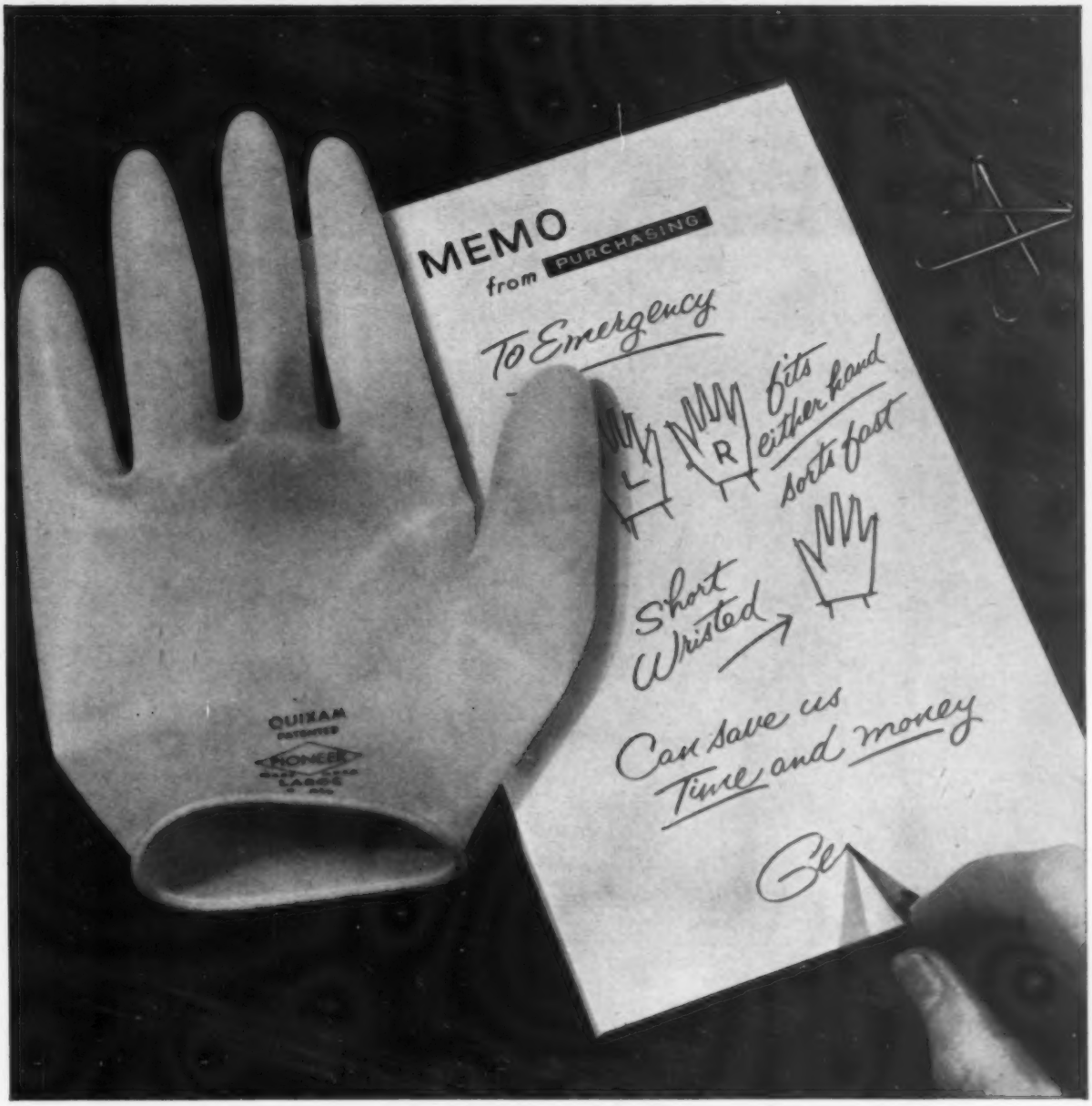
Preceptors Conferences are sponsored by the College for preceptors, course directors, and administrators considering the introduction of residency training programs in their hospitals. There is no tuition fee for these conferences. Registration applications may be obtained by writing to the College.

Dietetic Association Appointment

Dr. Rachel Beaudoin, P.Dt., director of the Institute of Dietetics and Nutrition, University of Montreal, was elected president of the Quebec Dietetic Association at the annual general meeting, April 20. She succeeds Miss Elizabeth Skinner, P.Dt., director of food services, The Bell Telephone Company.

Other officers of the General Council were also elected. They are: Sr. Mary Thomasina, P.Dt., vice-president; Miss Nancy Nash, P.Dt., secretary; Miss Marietta Blais, P.Dt., treasurer; and Miss Marian Bain, president-elect.

The Quebec Dietetic Association held a joint annual congress with the Quebec Hospital Association at the Queen Elizabeth Hotel.



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Thoughts From a Small Town
(Continued from page 50)

around the residence. Mowing the lawn and other routine jobs are still done by hospital staff. After our alert reporters referred to this project in the newspapers more "unorganized" volunteers appeared.

7. The folders printed by the Ontario Hospital Association for distribution with the patients' accounts elicited about ten compliments to each criticism. (This, no doubt, is the lazy man's way of offering opportunities to the patients to voice their complaints. Visits by the administrator and/or director of nursing or other key personnel are even more useful.)

8. A newspaper editorial headed "What's in a Name?" started the entire town talking about a possible change of name for the hospital. The name was not changed but for months hospital-consciousness reached new heights.

9. Service clubs making donations had their entire memberships invited to the hospital. Those who came were exposed to a full tour of the building before tea.

10. "Recognition Parties" honouring employees serving the hospital for five years or more were successful in many ways, one of which was the creation of an awareness in the community of the hospital's rôle as a major employer.

11. A fund-raising "Beach Day", with raffles and games of chance and skill, netted $1,600. One alert board member, who heard some criticism against such affairs in the past, rounded up a group of these grumblers, and made them "volunteer" to improve the affair. They proved themselves good workers, and there was no more open grumbling. Two other factors helped to make this project fruitful. By trying to attract children we succeeded in bringing them out as well as their parents (parades, bands, organized children's games were the means), and by providing simultaneously a free Salk vaccine clinic we softened the mercenary tone of our efforts.

12. The hospital's co-operation with the town's civil defence and disaster planning organization brought more favourable publicity.

13. Visiting restrictions in the paediatric wards — an old sore point with the parents — was made the subject of discussion at a meeting of the Home and School Association, with the hospital administrator as guest speaker.

Techniques

By now you have probably formed a mental picture of a sweating individual with an egg-head appearance, busily scheming and concocting ideas such as the above items. Nothing could be further from the truth; nearly all the ideas were volunteered by citizens. The only place where some administrative effort is required is in the job of keeping the lines of communication open.

The first step to effective communication is to keep representatives of the local news media informed. Our lazy approach to this problem was simple: those not elected to our board, were co-opted.

The news media then helped us to achieve the second step: credit given publicly for all good ideas. Many administrative achievements were attributed to community initiative or suggestions — proving that ideas are welcome.

The monthly board meetings

(Concluded on page 98)

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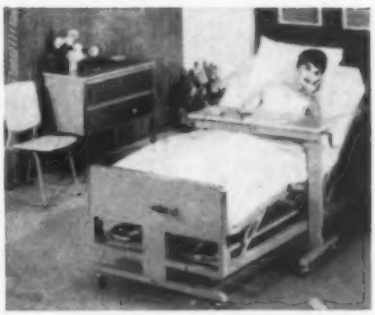
This is the store-room □ That's by the snack bar □ That's one of the rooms that Royal built!

This is the office □ That's near the store-room □ That's by the snack bar □ That's one of the rooms that Royal built! □

This is a room where the patients sleep □ That's smart and sleek □ That's over the office □ That's near the store-room □ That's by the snack bar □ That's one of the rooms □ that Royal built! □



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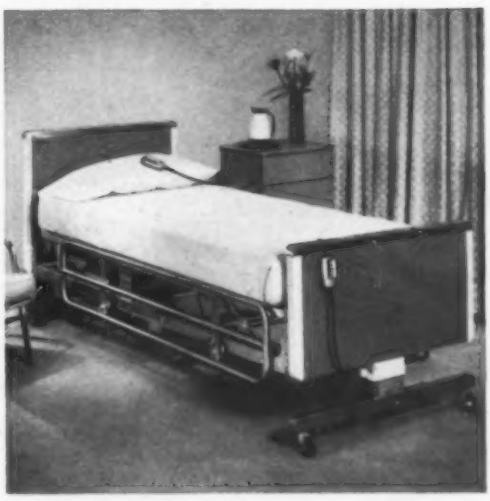

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Thoughts From a Small Town
(Concluded from page 96)

usually devote about 15 minutes to members' reports on recently heard opinions concerning the hospital. (Never underestimate the power of gossip!)

The board members, of course, must know the community well. Do not expect them to devote all their free time to the hospital, but let them participate in other civic affairs. Our directors are involved in nearly every religious, social, cultural, political and other organization in town.

The same thing holds true for your director of nursing and the administrator — with the possible exception of political organizations. Chatting with fellow church auxiliary members in service clubs, over a bridge table or at a tea helps two-way communication, and, what is most important, results in more people understanding that you and your hospital are integral parts of the community.

There is a danger to be noted at this point: many "experts" working only for short periods in a small town, consider themselves outsiders and hold themselves aloof from local activities. They should remember what Mr. Justic Holmes once said: "It is required of a man that he should take part in the actions and passions of his time, at the peril of being judged not to have lived".

Results

Most of the results of good public relations programs are difficult to measure. We have two figures to brag about: in 1958 (the last year of the previous administration) donations totalled less than $250, in 1959 and 1960 without any active campaign we collected over $25,000.

From our records we know that more people were hospitalized here recently (*i.e.* fewer felt the need to go to other hospitals), and that the average length of stay decreased. I cannot prove any connection between these facts and public relations — but I am happy. ■

Geriatric Program at Western Hospital

A new 44-bed ward at the Toronto Western Hospital, Ont., will be ready to admit its first patients next month. This ward represents a pilot project and is being established in the hospital at the request of Ontario's Department of Public Welfare to care for acutely ill residents of provincial homes for the aged. Elderly patients outside the welfare category may be admitted, but only when reserve beds are available. Persons from homes for the aged will receive top priority and should not have to wait longer than 24 hours for admittance.

The ward, when completed will have cost $300,000 plus another $30,000 for equipment. The provincial government contributed financial assistance to make this possible. The ward will contain 28 beds in four-bed units and 16 in two-bed units. The rooms have been designed with the comfort of the elderly uppermost in mind. For instance, realizing that many old people suffer from shortness of breath, especially in warm weather, the hospital has installed an air conditioning system at its own expense. Also, the bathrooms are equipped with sliding doors which can be opened easily by wheel chair patients.

The happiness of men consists in life. And life is labour.—*Ibsen*

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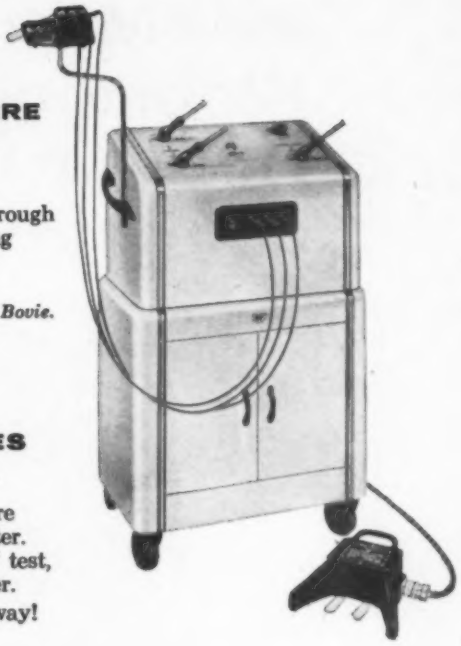

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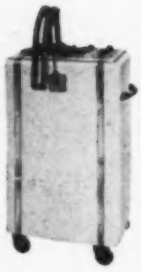

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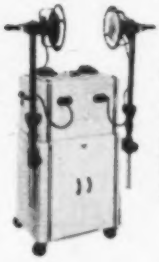

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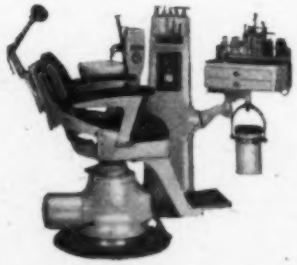

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This compact unit provides your hospital with complete facilities for thorough examination and treatment. The modern Ritter Chair means more comfortable, cooperative patients.

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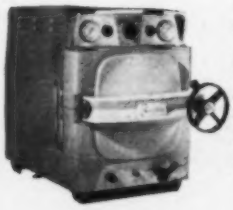

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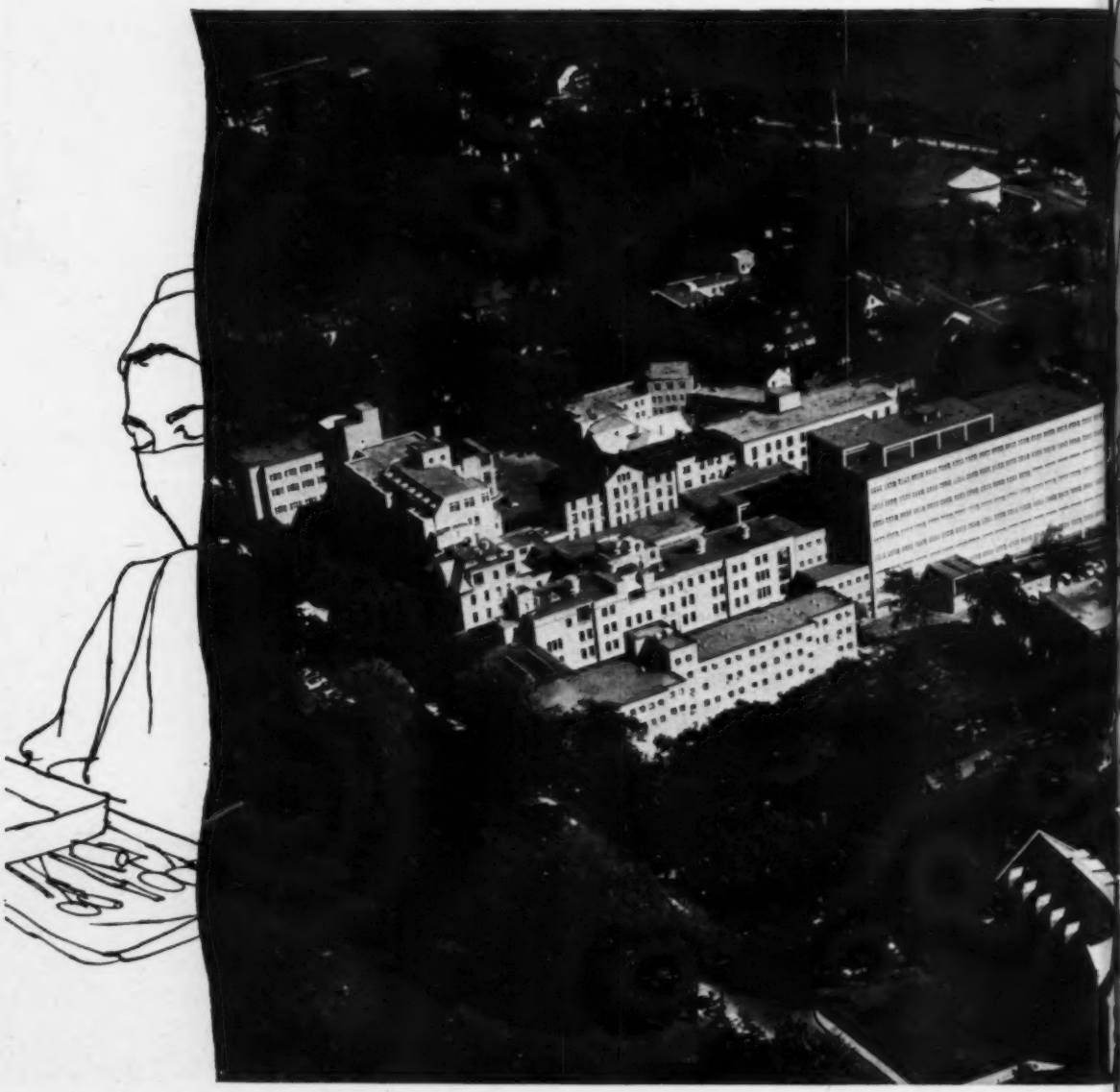

Honeywell Electronic Air Cleaners keep airborne dirt and bacteria from sterile areas

Kingston General Hospital wanted to keep operating rooms and delivery suites free from airborne bacteria so a Honeywell Electronic Air Cleaner was installed in the hospital's new Walter T. Connell Wing.

Honeywell engineers supervised the installation and start-up of the equipment, providing the necessary on-the-spot service to make sure peak efficiency was achieved as quickly as possible. Subsequent bacteriological assessments of the installation have been satisfactory.

A growing body of scientific opinion points to electronic air cleaning as the method of choice for control of airborne contamination of sterile areas in hospitals.

A Honeywell Electronic Air Cleaner can trap dust, dirt and virus particles as small as one 2½-millionth of an inch. It is 6 to 10 times as effective as ordinary mechanical filters.

For further information on how a Honeywell Electronic Air Cleaner can help control infection in your hospital, call your nearest Honeywell office or write Honeywell Controls Limited, *Commercial Division*, Toronto 17, Ontario.

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SINCE 1885

Schizophrenia Research Aided by Scottish Rite Grant

It is hoped that new leads concerning the puzzling relationship of schizophrenia to bodily functions may be forthcoming from studies of the adrenal gland carried out by a research team headed by Drs. Robert A. Cleghorn and Marion K. Birmingham at the Allan Memorial Institute of Psychiatry, McGill University, Montreal.

Continuation of the research project will be aided by a grant of $5,900 from the Supreme Council 33 degree Scottish Rite Freemasonry, Northern Masonic Jurisdiction. The cheque was presented on May 5 at a ceremony attended by officials of the council, the general director of the Canadian Mental Health Association, and the Allan Memorial Institute.

The McGill researchers have been concentrating on studies of the possible rôle of the adrenal gland in the development of mental disease. Under stress, the body of a normal man or woman responds with a balanced flow of hormones, increasing the supply if needed. The adrenal gland is believed to be especially active in response to stress conditions. Hunting for clues as to how it works, the McGill team has conducted experiments with the adrenal gland of the rat.

This project is one of 26 other schizophrenia research studies supported by the Scottish Rite Supreme Council in co-operation with the research program of the Canadian Mental Health Association. The council has awarded grants totalling more than $1,500,000 since its mental illness research program was started 28 years ago.

If you find yourself swimming in a current, do not struggle against it. You will exhaust yourself. The Canadian Red Cross Society in its water safety rules advises swimming with the current, and at the same time diagonally towards the shore.

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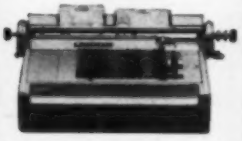

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"NEW DIMENSIONS / in electronics and data processing systems"

recent federal grants

Construction

St. Joseph's General Hospital, North Bay, Ont., will receive $39,104 to aid in the construction of a 13-bed residence for nursing sisters and to help meet the costs of alterations to rooms formerly occupied by nursing sisters. This space will be used for patients' beds.

A 206-bed hospital in Windsor, the I.O.D.E. Memorial Hospital and Essex County Sanatorium, will be granted $7,424 to improve services for 92 active treatment beds by the addition of nursing stations, medications rooms and kitchen facilities.

The Porcupine General Hospital, South Porcupine, Ont., will receive a grant of $65,930. This sum is to aid in the addition of 24 beds and two bassinets and for major renovations.

A grant, totalling $267,300 to Bowmanville Memorial Hospital, Bowmanville, Ont., will be used in the construction of an additional wing, increasing the bed capacity from the present 53 to 129. In addition, there will be provision for 30 new chronic-care beds.

The Victoria Union Hospital, Prince Albert, Sask., has been awarded a grant of more than $22,100. This sum will assist with the cost of improvements to the pharmacy, central supply facilities and the morgue.

Two new hospitals will be erected in Saskatchewan with the assistance of grants totalling more than $74,900. The Pangman Union Hospital, Pangman, will receive $30,900 which will be used to help build their new hospital with 12 active treatment beds, a four-bassinet nursery and correlated services. The Norquay - Canora Union Hospital, Norquay, has been granted $43,993 to assist in the building of a larger hospital. The new hospital will be equipped with 17 active treatment beds and a six-bassinet nursery.

A $455,000 grant has been awarded to assist in the construction of the Regional General Hospital, Nanaimo, B.C. This $4,000,000 project will supplement the existing facilities of the Nanaimo General Hospital and the Nanaimo Indian Hospital. The building, to be completed in 1962, will have 184 active treatment beds, 43 bassinets, areas for an out-patient department, and other modern medical and surgical facilities. When the new hospital is in operation, it is expected that the present Nanaimo General Hospital will be converted to the care of convalescent and chronic patients.

The Halton County Health Unit in Ontario will receive $24,246 to assist in the establishment and maintenance of a community mental health clinic.

The Woodstock General Hospital, Woodstock, Ont., has been awarded a grant of $9,000 for the erection of a 12-bed nurses' residence. The new two-storey building will accommodate senior nurses, thus releasing existing facilities at the hospital for student nurses and living-in staff.

A grant of $20,425 has been allotted to help meet the costs of renovating the Perley Building of the Royal Ottawa Sanatorium, Ottawa. The building will be thoroughly renovated to provide modern heating, plumbing, electrical and dietary services, and bed accommodation for children with tuberculosis. When the work is completed about mid-summer, the Whitney Building, now being used for the care of tuberculosis patients, will be released for the short-term care of mental patients.

Two building projects submitted by the Verdun Protestant Hospital, Verdun, Que., have just been approved under the federal hospital construction grant. Totalling $433,000, the grants will assist in building the initial two units of a centre for the treatment of psychiatric patients in the adolescent group, as well as a mental deficiency unit.

Hôpital St-Luc, Montreal, Que., has been granted a sum of more than $262,900 to help meet the construction cost of the nurses' residence. The new building, construction of which has already been completed, has accommodation for 227 beds and includes classrooms, laboratories and an auditorium. The former residence, with a capacity of 122 beds, will be converted to accommodate interns,

psychiatric patients and employees.

Construction of a new general hospital in Repentigny, Que., will be assisted by an allocation totalling over $177,300. Hôpital Le Gardeur, the first general hospital to be established in Repentigny, will provide accommodation for 63 beds, 23 bassinets, six nurses' beds, and modern medical, surgical and obstetrical services.

Research

The University of Toronto, Toronto, Ont., has been awarded $9,300 to aid its Schools of Hygiene and of Nursing in a research project to establish the particular duties and responsibilities associated with occupational health nursing in Canada.

Under the Medical Rehabilitation and Crippled Children grant, the University of Toronto will receive $7,300 to assist in increasing the knowledge of neuronal changes occurring following the injury of a nerve. It is hoped that the results of the research may have direct application to the rehabilitation of persons injured in accidents. The work, expected to require at least two years study, will be carried out at the Banting Institute, under the direction of Dr. J. Olszewski, professor of neuropathology.

A grant of $13,250 for research into the causes of infant mortality has been approved for the Research Institute of the Hospital for Sick Children, Toronto, Ont.

The Division of Tuberculosis Prevention of the Department of Health of Ontario will receive $16,410 towards a continuing long-term study of former tuberculosis patients.

The University of Toronto has been awarded a grant of $12,300 to carry out a research project on contamination in swimming pools. Under the direction of Dr. J. R. Brown of the School of Hygiene, the proposed work will be based on a study of changes in the chemical constituents of swimming pool water by analyzing selected samples. It is intended to correlate the chemical findings with the results of simultaneous virological and bacteriological investigations made on the same pools. The object is to assess the level of human contamination in public swimming pools.

Education

The department of psychiatry of the University of Western Ontario, London, Ont., will receive $8,250 to expand its post-graduate training program in clinical psychiatry.

Food Additives

(continued from page 63)

interested in the methods of evaluating the safety of additives and I refer you to a paper published in *Canadian Journal of Public Health*, October 1959, for further details.

A general statement covering safety might be that the additive after full toxicological examination on test animals is generally recognized as being safe among experts qualified by scientific training and experience to evaluate the safety of chemicals. The toxicologist in predicting a safe level of an additive for human beings based on his findings on animals, uses a safety margin usually referred to as "100-fold margin of safety". That is to say that the chemical additive should not be used in food in a quantity greater than 1/100 of the amount, *i.e.* a maximum safe dosage in long-term animal testing.

A practical example which has been greatly simplified might be: after chronic toxicity testing on two or more species of animals, a safe level is estimated for each specie. In the testing referred to, it was found that the animal could tolerate two parts per million of chemical A per kilogram body weight. Based on a 70 kilogram man, this figure becomes 140 parts per million. Applying the 100-fold safety margin we now arrive at a figure of 1.4 p.p.m.

Taking the example one step further, it is quite possible that in testing the effectiveness of the chemical for its intended use it would be found that a level of .5 p.p.m. was sufficient. The tolerance would then be set at this figure and now we have a 300 "fold margin of safety".

I would like now to discuss with you the Directorate's proposals for future requirements. It will be appreciated that legislative control measures for health protection are constantly changing, these changes being demanded by our changing environment.

Our Directorate has a very close liaison with the Food and Drug Administration in Washington and we have watched closely for any possible areas in their control that might be used to our advantage. The control exercised in Canada must, of course, be within the legal authority of the Food and Drugs Act and it is felt that Section 24, (1) gives to the Governor in Council the authority to promulgate regulations which will specifically require the conditions that must

be satisfied before a substance is introduced into the food supply. This would take the form of requiring a submission before a tolerance could be established. This tolerance would then be included in the regulations as a permitted food additive. If no tolerance has been provided and the additive is found to be used, this would be considered as a violation of the regulations.

To put these proposals into effect will require the establishment of a list of substances which, on the basis of present knowledge, could be considered safe for use in foods. To this end, our director, Dr. C. A. Morrell, called a meeting of representatives of all trade associations of the food industry in Ottawa, early in April of 1960. These representatives were informed of our plans and provided with copies of the proposed list consisting of approximately 230 substances under several headings. They were informed that when the proposed regulations go into effect, an acceptable list of food additives will also be introduced. No additional information will be required for those substances included on the list. However, substances not provided for will have to meet the requirements of the new regulations. It was therefore emphasized that it would be in the best interests of all concerned to have this list include all acceptable substances at the time that it is promulgated.

Comparison of U.S. Legislation and Proposed Canadian Legislation

Many of you have become exposed to the subject of food additives in your daily reading and no doubt the majority of your references pertained to legislative control in the United States, since many of our magazines originate there and this subject has received very wide publicity with the problem associated with cranberries and poultry.

Let us look for a few minutes at the control exercised in the United States and the recommendations of the World Health Organization.

In Geneva in 1955, fourteen countries, including Canada, met in a joint F.A.O./W.H.O. conference to discuss this subject, and after subsequent meetings stated that "legal control of food additives should be based on the principle of a permitted list".

This basic principle is embodied in the Food Additive Amendment in the United States and in the new regulations which are currently under consideration in Canada.

The American legislation outlines in detail the method which the Secretary of Health, Education and Welfare must use in handling a petition for the establishment of a tolerance. Under these regulations there is a requirement that no tolerance shall be established if, on fair evaluation of the data, it fails to establish that the proposed use of the food additive will be safe, provided "that no additive shall be deemed to be safe if it is found to induce cancer when ingested by man or animal, or if it is found, after tests which are appropriate for the evaluation of the safety of food additives, to induce cancer in man or animal". This section is referred to as the Delaney clause, and it has been extremely controversial and, of course, was the basis of the action taken in the case of aminotriazole on cranberries and the use of stilboestrol in poultry.

The present wording of the Delaney clause, as you can appreciate, makes no allowance for the possibility of a no-effect level of the chemical. The agency responsible for the enforcement of this legislation has no authority to employ any administrative judgment based on the rule of reason and scientific judgment.

My comments on this legislative control should not be construed as either for or against, but only as my interpretation of the law as it exists.

Insofar as present proposals on this subject in Canada are concerned, our assistant director, Dr. R. A. Chapman, had this to say when addressing the Canadian Institute of Food Technology National Convention, Winnipeg, in June, 1960: [8]

"We are faced with a very difficult but also a very important task. We have no evidence for the existence of any health hazard that necessitates immediate action. We propose, therefore, to take all the time that is necessary to reach sound decisions employing 'the rule of reason based on scientific judgment'. Finally, we do not consider it necessary to adopt any so-called 'cancer clause'. Any carcinogenic properties of a compound are simply another manifestation of toxicity and we believe should be judged as such. On this premise and with the active co-operation which has been promised us by informed individuals and groups knowledgeable in this field, I believe that it should be possible to develop regulations and a list of

acceptable food additives which will not be too restrictive but will provide the necessary authority to reduce to a minimum any possible hazard to health."

References

1. E. N. Todhunter 1960 *Food Drug Cosmetic Law Journal*, Vol. 15 No. 1.

2. *Office Consolidation of the Food and Drug Regulations*—Queen's Printer, Ottawa.

3. Chapman, R. A. 1961 *Canadian Food Industries*, January. ■

Book Reviews

(concluded from page 86)

three American psychiatrists and a psychiatric nurse who made an intensive six-week study of psychiatric programs in Great Britain, Belgium, Denmark, France, and Holland.

The individual programs surveyed are services, including outpatient departments, residential hospitals, and family care; hospital administration; therapy and rehabilitation, with emphasis on work with remuneration as a therapeutic measure; and professional training and research.

The report concludes with a comparison of American and European programs. The book will be of interest not only to the staffs of mental hospitals but also to all others seeking to improve the lot of the mentally ill.

PAEDIATRIC SURGERY FOR NURSES by Edward G. Stanley-Brown, M.D. Published by W. B. Saunders Co., Philadelphia, 1961. Canadian agents, McAinsh & Co. Ltd., Toronto, Ont. Illus. Pp. 172. Price $5.00.

The progress made in the surgery of infants and children over the last three decades and the many differences between adult and paediatric surgery have increased the need for a textbook such as this. The book presents, in a simple and practical manner, some of the conditions of infants and children which require surgery; in short, it will provide the nurse with a usable description of a given condition, an understanding of the steps which lead to accurate diagnosis, and an idea of the fundamental principles followed in surgical correction.

There is a bibliography at the end of each chapter, and these will serve as guides to the nurse who wants to delve into the subject more deeply.

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 25 Imperial St., Toronto 7, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch of fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge, ¼ page display advertisement—$35.00. Advertisements must be received by the first of the month to appear in that month's issue.

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For modern general hospital, expanding to 50 beds and 12 bassinets, to be completed in 1961. Residence accommodation available.

Salary commensurate with experience and qualifications.

Apply, giving full particulars of training and experience, to:

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AUTOCLAVE — mattress sterilizer, double door, 7'x3'x3½'. Mfg. by American Sterilizer Co. $1,500.00, good condition.

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MATTRESS COVERS — cot size, unbleached cotton, new, $1.50.

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For 75 bed hospital. Salary according to qualifications and experience. Apply to Superintendent,

Carleton Memorial Hospital,
Woodstock, New Brunswick.

Qualified Dietitian

For 250 bed, modern, accredited hospital in Georgian Bay Area. Duties to commence July 15, 1961, if possible. Degree in Home Economics or Household Science essential. Duties include teaching Diet Therapy to student nurses. Salary commensurate with qualifications and experience.

Apply to: The Administrator,
General and Marine Hospital,
Owen Sound, Ontario.

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For St. Joseph's Hospital, Victoria, B.C., Canada. Applicant must have a medical degree and training in Hospital Administration or equivalent experience. Duties will include responsibility for liaison with medical staff and functional officer of certain professional departments.

St. Joseph's Hospital has a capacity of 448 with plans for immediate expansion.

Applications should state qualifications, experience, age, salary expectation and to be addressed to:

Sister Mary Ann Celesta,
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Victoria, B.C.

Administration Consultant

Graduate in Hospital Administration required for hospital counselling, educational and advisory services by voluntary Association.

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Box 642A,
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Position Wanted
Assistant Administrator

Aged 36, this person has broad experience in Personnel Administration in both hospitals and in civic government, is currently completing post-graduate study in Hospital Administration and is available immediately. A detailed outline of education and experience will be provided on request.

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Applications are invited from Registered, experienced Dietitians with Membership in the Canadian Diatetic Association, for appointment to the post of Director of Dietetics at the new Brantford General Hospital, of 550 beds, located in the progressive City of Brantford, 65 miles west of Toronto.

Excellent working conditions, and liberal benefits.

Salary will be set in accordance with qualifications, and experience.

Please address inquiries to:
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Well equipped, modern, accredited General Hospital, 382 beds, requires a Chief Dietitian. R.P.Dt. and Canadian Dietetic Association Membership required.

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Modern and comfortable suite accommodation, 40-hour week, 1 month vacation with pay, excellent personnel policy, with conventional benefits.

Salary open to discussion, pending experience and qualifications.

Please apply to: The Executive Director, P.O. Box 1000, Ste. Agathe des Monts, P.Q.

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729 bed hospital now adding 600 more beds. Large new school for nurses. Medical under-graduate teaching. Either medical or non-medical background acceptable. Experience needed. State qualifications and salary expected. Please furnish references.

Apply: Chairman,
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Room 304,
Bank of Commerce Bldg.,
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We have 2 National Cash posting machines (series 2000) for sale; one is 19 years old, and one is 5 years old. The 19 year old machine is set up for posting out-patient Accounts Receivable and the 5 year old for in-patient Accounts Receivable.

Anyone interested please contact Mr. S. G. Anderson, Assistant Executive Director, Ottawa Civic Hospital.

The Victoria General Hospital

- a 558 bed hospital -

Halifax, Nova Scotia

Requires the Services

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Gross Salary Range: $3,480 - $4,050 in accordance with experience.

Full Civil Service Benefits. Accommodations available in modern residence. Applications are also invited from Registered Nurses for general duty. For further information apply to Director of Nursing, Victoria General Hospital, Halifax, Nova Scotia.

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Applications are invited for the position of Associate Director of Nursing Education for a School of Nursing with approximately 200 students.

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Baccalaureate degree desirable, but not essential if adequate post graduate experience in nursing education or if holding university certificate or diploma in the field of nursing education.

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Apply to: **Director of Nursing, General Hospital, St. John's, Nfld.**

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For 300 bed hospital. Degree in home economics, household economics or household science. Plus one year directed post-training or 2 years' hospital experience are essential. Expansion program planned for 600 beds. Salary commensurate with qualifications and experience. 40 hour week and 3 weeks vacation.

Apply to: **Chief Dietitian, The Wellesley Hospital, 160 Wellesley St. E., Toronto 5, Ontario.**

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Director of Nursing wanted. Modern 750 bed accredited civic general hospital (200 bed addition being built). Responsible position. To plan and direct education (of 300 students) and service programs. Perquisites include suite with service, pension plan, four weeks vacation, sick benefits. Salary $7,000.00-$9,000.00 annually depending on qualifications and experience. Duties to commence as soon as possible. Address replies to Chairman, Calgary Hospitals Board, Calgary General Hospital, Calgary, Alberta.

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Applications are invited from dietitians with membership in the Canadian Dietetic Association for the posts of Chief Dietitian and two assistant dietitians at the General Hospital, St. John's, Nfld.

This is a 456-bed acute General Hospital which has recently enlarged its Dietary Department and Cafeteria.

Transportation will be provided to Newfoundland for the successful applicants. Interested parties are invited to write giving full details and salary expected, to:-

The Superintendent,
The General Hospital,
St. John's.

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Applications are invited for the position of Dietitian at the Victoria Union Hospital, Prince Albert, Saskatchewan. Excellent facilities built in 1959 for food service. **Apply, stating qualifications, to H. Bassett, Administrator.**

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Wanted to assume responsibility for Department in a 100 bed hospital, expanding to 230 beds, situated near Toronto. Comfortable residence accommodation available.

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Scenes include a view in a Maryland hospital which contrasts a modern plastic door with a bulky, conventional cold storage door constructed of wood and metal. Clean-looking white doors are contrasted with both painted and polished metal wall surfaces at a Howard Johnson restaurant in Queens, N.Y.

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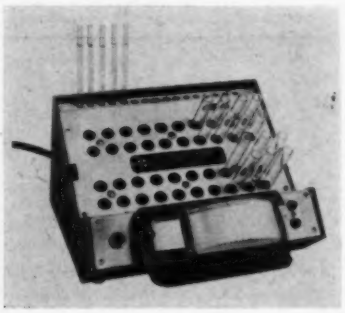
With the introduction of the "Thrombitron", prothrombin time determinations can now be done practically and accurately without the use of a water bath. The new instrument is designed for use with standard "tilt" or "loop" methods.

The Thrombitron brings all the necessary test components within finger tip reach of the technologist seated at the lab table and maintains plasma, thromboplastin, and prothrombin pipettes at a constant 37° C temperature without a water bath. It is designed for both accepted "tilt" or "loop" methods and guarantees highly accurate, reproducible results. A constant light source and magnifying viewer assure accurate observation. The Thrombitron is a model of simplified efficiency; it has no moving parts, no complex electrical circuits, no maintenance problems.



The Adams Pedichron, an electrical foot switch holding and operating any standard stop watch, is available for use with the Thrombitron. The Pedichron not only frees the hands of the technologist but can be used in other work requiring split-second timing.

For further information on these two products, write to Clay-Adams, Inc., 141 East 25th St., New York 10, N.Y.

Multiple-Copy, Standardized Hospital Record Forms

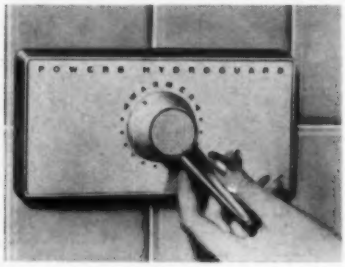
Physicians' Record Co., publishers of hospital and medical records, announce the addition of a new standardized group of snap-out, carbon-interleaved, multiple-copy record forms for hospitals. Two-part, three-part, and four-part styles are stocked for immediate shipment.

The forms include a "Summary and Record of Admission", "Nurses' Notes", "Report of Operation", "Tissue Report", "X-ray Report", 'Electrocardiographic Report", and a "Purchase Order" which is imprinted with the hospital name and numbered. Write to the Physicians' Record Co., 3000 S. Ridgeland Avenue, Berwyn, Illinois, requesting "Sample Group 200".

Hydroguard Shower-Tub Control Features New Design

A new model Powers Hydroguard Thermostatic Shower-Tub Control has just been introduced. It is restyled in a satin chrome case with an easy-grip pointer handle. Internal construction is completely redesigned but still retains all the safety features for which the Hydroguard is known. Among these are prevention of scalding water even if the handle is turned to maximum hot position; prevention of sudden bursts of hot or cold water, regardless of the use of other plumbing fixtures; and simplicity of single-handle operation.

The heart of the Hydroguard is a sealed thermal element with only one moving part which prevents delivery of water above 110°F. Failure of cold or hot water supply automatically and immediately shuts off delivery. This complies with Federal Specifications WW-P-54 lb.



The Hydroguard can be installed with either concealed or exposed piping. By maintaining exact water temperatures, the Hydroguard conserves both water and fuel. Internal parts are easily accessible from the front simply by removing handle and dial. The entire mechanism is designed for dependability, minimum maintenance and long service-life.

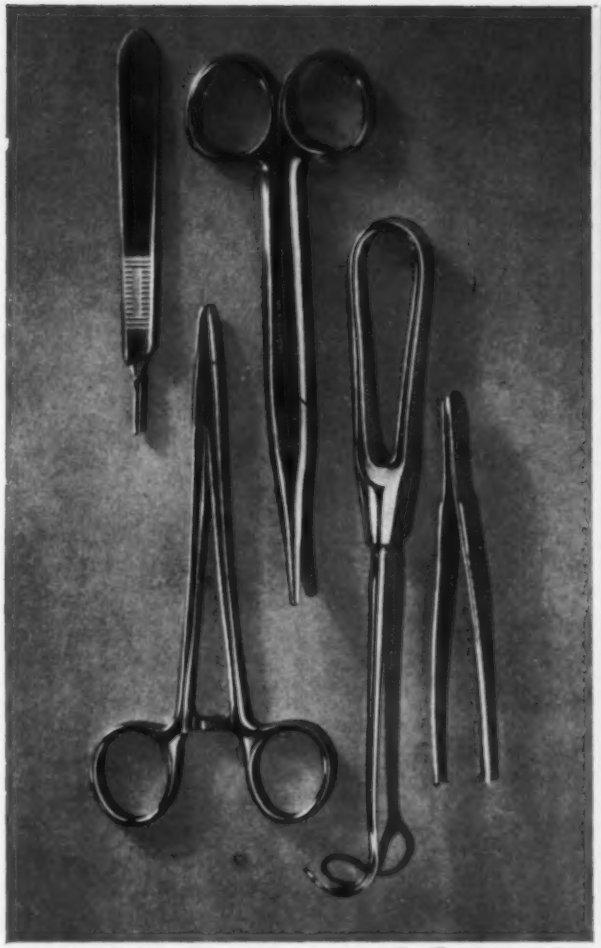
For additional information, contact The Powers Regulator Company of Canada, Ltd., Dept. H-1, 15 Torbarrie Rd., Downsview, Ont.

Two New Cubers and Bin Announced by Scotsman

Scotsman Super Cubers SC-300, SC-300W and allied bin Model BH-650 are now available from Scotsman, Queen Products Division of King-Seeley Thermos Co., Albert Lea, Minnesota.

The two new cubers, Model SC-300 air-cooled (illustrated) and Model SC-300W water-cooled, were especially designed for moderate

(continued on page 114)



FROM O.R. PROCEDURES TO HOUSEKEEPING

Wescodyne with "Tamed Iodine" destroys the widest range of micro-organisms — cleans and disinfects in one step

Wescodyne is formulated with "Tamed Iodine." It non-selectively destroys bacteria, viruses, spores, fungi, *even resistant types of staph.*

Wescodyne improves upon, and eliminates the need for, a wide variety of products. Its strong detergent action combines cleaning and disinfecting in one step.

In solution, Wescodyne is non-toxic, non-staining, non-irritating. And virtually odorless. At recommended dilution, Wescodyne has a rich amber color. As long as the color remains, positive germicidal activity continues.

Astonishingly enough, Wescodyne costs only a few pennies per gallon at general-use dilution.

WEST CHEMICAL PRODUCTS LTD.
WEST DISINFECTING DIVISION

For full information, results of scientific evaluations, and recommended O.R., housekeeping and nursing procedures, simply complete and mail coupon below. West Chemical Products, Ltd., 5621-23 Casgrain Ave., Montreal.

"Wescodyne" and "Tamed Iodine" are Reg. T.M.'s of West Chemical Products, Ltd.

Technical Advisory Service
West Chemical Products, Inc.
42-16 West Street, Long Island City 1, New York

Gentlemen: ☐ Please send available literature
☐ Have your representative call

Name_____

Title_____

Address_____

_____

City_____ Zone____ State_____

W

Suppliers Tell Us —

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users of ice such as medium-sized hospitals, restaurants, hotels, et cetera.

Both models produce up to 300 lbs. of cubes per day and are sold with or without an integral ice crushing component for crushing capacity of up to 30 lbs. of ice per minute. The SC-300 Super Cuber automatically stores cubes and features the efficient "Scot-O-Matic" ice making mechanism developed by Scotsman.

The freezing system includes a ¾ hp hermetically sealed air-cooled compressor (water-cooled on SC-300W) using "Freon 12." Carrying 5-year warranties, units operate on either 110 or 230 volts, 60-cycle, single phase current. The easy-to-clean steel cabinets are finished in grey hammerloid, with stainless steel and chrome trim. All stainless steel cabinets are available.

Of unusually compact functional design, the SC-300 series occupies only 8 sq. ft. of floor space when used in conjunction with the B-400 bin (10.2 with 650 bin). It is 70⅛" high (80⅛" with optional C5B Crusher), 42⅛" wide, and 29½" deep.

Complete information is available from any Scotsman distributor or dealer, or directly from factory.

New Red Medical Utility Gloves from Pioneer Rubber Co.

Positive hand protection, tailored construction, and greater working comfort — all features essential to specific functions in the hospital, and mortuary fields requiring the safeguarding of hands—are provided by the new U-36 medical utility gloves just introduced by The Pioneer Rubber Company.

The red gloves feature a knit-cotton lining permanently bonded to a rugged pylox coating for their full 14½ inch length. The pylox material, a Pioneer exclusive, provides maximum flexibility for working comfort and gives outstanding performance. It is exceptionally resistant to oils, greases, acids, most chemicals and substances known to deteriorate ordinary rubber.

U-36 design and construction provide: insulation for the hands from hot and cold temperatures; complete liquidtight protection—hands stay dry and free from irritating substances; long-lasting performance—the Pylox coating remains soft and flexible despite repeated contact with agents normally destructive to ordinary gloves; safer-than-barehand grip on wet, slippery objects due to an exclusive non-slip finish.

The new Pioneer medical utility gloves are available in small, medium and large sizes from supply houses featuring the Pioneer glove line or directly from The Pioneer Rubber Company, 396 Tiffin Rd., Willard, Ohio.

AGA Hospital Equipment from Sweden

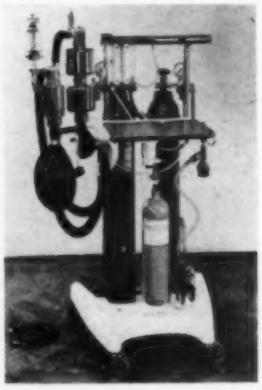
From Sweden—with its reputation for fine optical and surgical instruments—comes a range of precision hospital equipment that is new to Canada, although it has been used in European hospitals for over 25 years.

AGA (Svenska AB Gassaccumulator) is today an international concern with technicians at work in 25 countries, manufacturing an immense variety of precision-built equipment for hospital use.

The range of AGA equipment falls into five categories: General anaesthetic apparatus, the heart-lung machine, incubators, oxygen therapy equipment and injector suction devices.

The Anestor General Anaesthetic Equipment is described herewith: The functional design makes it simple to use with maximum safety. The 3 flowmeters and dosage devices are in one unit for easy supervision and adjustment; self-sealing plug-in connections allow quick cylinder changes and can be used on station outlets; with the tight-fitting cone connections, soda lime canisters can be changed during surgery; earthing chains prevent an accummulation of static electricity; non-interchangeable connections and tubes of differing sizes and colours eliminate errors in coupling.

All Anestor models administer oxygen, nitrous oxide, ether and cyclopropane with the closed circuit system; a bubble vaporizer can be added when giving fluothane, a Waters absorber is used for the to-and-fro technique and a trilene vaporizer administers in the semi-open system.



Wide bores and large-sized valves throughout the circulation system reduce resistance to breathing to a minimum.

All parts in contact with the respiratory gases can be sterilized in an autoclave.

The entire range of AGA anaesthetic and respiratory apparatus will be distributed across Canada through Liquid Carbonic Canadian Corp. Ltd.

Write to their Montreal office for additional information.

Primer of Radiation Protection is Ansco Publication

A handbook entitled, *A Primer of Radiation Protection*, is now available. The purpose of the book, according to the author,

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R. J. Schulz, assistant professor of radiology (Physics), Albert Einstein College of Medicine, is to present a concise introduction to the physical aspects of radiation protection.

This 40-page book offers a bibliography of existing works on the subject and presents charts, curves and photographs as illustration. Chapters are devoted to radiation units, maximum permissible dose, absorption processes and radiation shields, determination of shielding requirements, radium and radioisotopes, and radiation detectors.

A Primer of Radiation Protection is published by Ansco, a Division of General Aniline and Film Corporation, and is offered without charge to resident physicians in radiology, radiologists, X-ray specialists, and other interested individuals and organizations.

Please write to Ansco of Canada, Ltd., 1450 Queensway, Toronto.

Pre-Sterilized Cord-Clamps Are Gas Sterilized

The Hollister Umbilical Cord-Clamp is now available in individual pre-sterilized packets and at a new reduced price. Volume production has allowed Hollister to offer these savings to hospitals while providing a gas sterilized Cord-Clamp for the very first time.

The lightweight disposable clamp is made of tough, resilient nylon, fits any size umbilical cord and maintains a constant pressure as the cord shrinks. Already in use in thousands of hospitals, the Cord-Clamp snaps permanently shut in a second with one hand, is usually removed after 12 hours and requires no dressings.

The Cord-Clamp is also available in unsterilized form, as before, for hospitals that prefer to autoclave it with the OB instrument pack.

Additional information and samples may be obtained by writing to Hollister Ltd., 160 Bay St., Toronto 1, Ont.

New Magnifying Index Guides by Seeley Systems

Seeley Systems of Canada Limited have announced a new line of index guides called "See-Fast". These guides consist of changeable printed inserts in plastic magnifying lenses, tilted to meet the eye.

This principle has already been tested and approved in Seeley See-Fax vertical visible filing systems and is reported to have proven a great time saver. Now the See-Fast guides are available for all filing applications.

Seeley has also announced that the new guides are available in exclusive, new Canadian standard alphabetical subdivisions, compiled from Canadian listings and very different to the standard U.S. subdivisions. This feature is another major time saving factor, according to the company. See-Fast guides are available in 10 to 5000 subdivisions from A to Z—in any size. Various insert colours provide limitless colour coding possibilities.

Write Seeley Systems of Canada, Ltd., 32 Mendota Rd., Toronto 18, Ont.

Beam Metal Specialties Issue New Catalogue

Beam Metal Specialties, Inc., has its new catalogue ready for distribution. The new binding allows the catalogue to be identified from the shelf as well as from the master file.

Individual sections by product identification are available.

Included in the 36 pages are the new products, chart racks for desk and wall hanging, wheeled chart carriers and BMI cards.

The catalogue, or sections, are available to qualified dealers and hospital personnel. Please send inquiries to Beam Metal Specialties, Inc., 25-11 49th Street, Long Island City 3, New York.

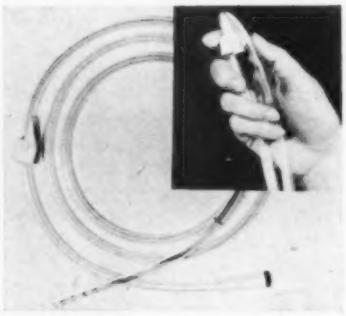
A. T. I. Expands Facilities in Hollywood

Completion of a large, new addition to its plant in North Hollywood, California, has been announced by the Aseptic-Thermo Indicator Company. The extra space was much needed, according to President Willard M. Huyck, to accommodate A.T.I.'s enlarged research department and its constantly expanding facilities. New bag-making machinery has been installed, as well as new chemical production equipment.

A.T.I. produces all the chemical formulations for its many indicator products. Huyck stated that the increased plant capacity was necessary, not only because of the steadily increasing demand for its well established products, but because of the reception of new products recently developed through continuing A.T.I. research. These new products include A.T.I.'s Ethylene Oxide Indicator for high pressure, flash autoclaving now in use in many hospitals.

Enema Tube with New Bard "Quick-Clamp"

Bardic brand Enema or Harris flush tubes are now equipped with an ingenious plastic shutoff clamp that is easily operated with one hand.

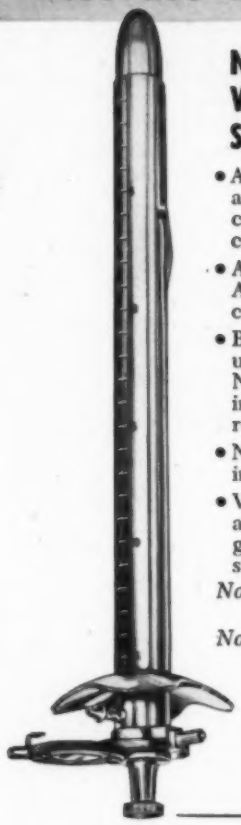


Flow is stopped by bringing the tube back over the clamp edge and pushing it into the slot, as shown. The tubes are 24 French, 60″ long, marked 5 inches from distal end. The flexible connector fits all standard enema cans.

Full details from C. R. Bard, Inc., Murray Hill, N.J.

(continued on page 118)

Dependable WELCH ALLYN instruments speed accurate diagnosis and simplify hospital procedure



New, simpler Welch Allyn SIGMOIDOSCOPE

- All parts are sterilizable by autoclaving, even the light carrier, lamp and connecting cord.
- All parts are interchangeable. Any obturator or light carrier can be used with any speculum.
- Brilliant distal illumination of uniform spot type with WA No. 2 lamp projects light deep into cavity. Lamp is unusually rugged and long-lived.
- No specular reflection. Serrated interior eliminates glare.
- Vision is unobstructed. Lamp and light carrier are recessed, giving maximum space for instrumentation and observation.

No. 311, sigmoidoscope, 25 cm. length.

No. 312, proctoscope, 15 cm. length.

Unique Welch Allyn ROTATING ANOSCOPE

facilitates examination and instrumentation

- Speculum can be rotated without moving handle. Simple gear mechanism turns speculum through full 360°
- Orbiculated edges minimize discomfort as speculum is rotated, even in the presence of rectal pathology.
- Entire instrument can be autoclaved or boiled, including the light carrier and lamp.
- Brilliant self-illumination with durable WA No. 2 lamp.
- Fits all standard WA handles, including new rechargeables.

No. 288, rotating anoscope, with light carrier.

Diagnosis is faster and easier with a Welch Allyn OPHTHALMOSCOPE

All the famous WA "oph" features are included, plus complete one-hand control of all functions, detachable rubber hood, extraneous light shield, removable condensing lens, and functional, modern design. Fits all WA handles.

No. 121, ophthalmoscope, with rubber hood.

End battery replacements

Newest Welch Allyn RECHARGEABLE HANDLE

- Fits all WA medium-handle set cases
- Provides satisfactory illumination longer between charges than standard medium batteries.
- No separate charger.
- Cannot corrode.
- Cannot overcharge.
- May be recharged thousands of times.
- Fits all WA instruments.

No. 717, Rechargeable battery handle.

No. 717-B, Extra bottom section.

Doctor's perennial favorite—

Welch Allyn OTOSCOPE

The famous diagnostic otoscope so popular the world over. Brilliant illumination, very large magnifying lens, convenient lens frame design, durable, trouble-free construction. Fits all WA battery handles.

No. 201, diagnostic otoscope.

J. F. HARTZ CO. LIMITED

Toronto Montréal Hamilton Halifax

THE STEVENS COMPANIES

Toronto Winnipeg Calgary Vancouver

CASGRAIN & CHARBONNEAU, LIMITÉE

Montréal Ottawa Québec

Suppliers Tell Us —

(continued from page 116)

Arthur H. White is Clay-Adams Appointee

Harry Roth, president of Clay-Adams, Inc., announces the appointment of Arthur H. White as director of marketing and product development.

Mr. White, a graduate of Harvard University and the Harvard Graduate School of Business Administration, also served on the staff of the Massachusetts Institute of Technology. For the past ten years he was a senior associate of the consulting firm of Stewart, Dougall Associates. During this period he assisted many companies in the medical and scientific field in their marketing and product development projects.

Arthur H. White

Under Mr. White's direction the company expects to pursue more vigorously its research and development of new products as well as its marketing efforts.

Dixie Cup Sales Management Appointments

A. H. Pickup, general sales manager, Dixie Cup Company (Canada) Ltd., Brampton, Ontario, announces the following promotions in the marketing division: F. E. Piercy to assistant to the general sales manager; W. I. Dickins to regional manager, Province of Ontario; P. E. Feltus to regional manager, Manitoba, Saskatchewan and Alberta; and A. T. Romanick to supervisor, broker and syndicate sales. "These promotions", said Mr. Pickup, "form part of a re-alignment of sales management responsibilities to provide increased service and attention to Dixie distributors and brokers".

F. E. Piercy

Mr. Piercy, for many years territory manager in Ontario, brings to his new position an excellent background in all markets important to the paper cup and container industry.

I. Dickins originally joined the U.S. company, transferred in January, 1954 to become Western Ontario sales representative, a position he held until the present time.

P. E. Feltus, prior to his appointment, was sales representative headquartered in Quebec city. Previous assignments included special merchandising work in all parts of Canada and also as a sales representative in New York city. He joined Dixie Cup in February, 1954.

G. A. Braun Appointment in Western Canada

G. A. Braun, Inc., pioneer manufacturer of laundry washer-extractors, has appointed Gordon Fawcett as factory sales and service representative in Western Canada for the provinces of British Columbia, Alberta and Saskatchewan.

Gordon Fawcett

Mr. Fawcett formerly served with the Canadian Military Police and for four years was manager of the Deluxe Cleaners and Launderers Limited, Petawawa, Ontario. He has completed his training at the factory in sales and service and will be specializing in the institutional, linen supply and commercial laundry fields.

Harry Geen is Aeroplast Canadian Representative

Harry Geen has been appointed to represent Aeroplast Corporation of Dayton, Ohio, in Canada.

Harry Geen

Mr. Geen will work with Aeroplast Corporation's distributors in Canada.

Vi-Drape Film and Vi-Hesive Adherant, the bacterial barrier to isolate the patient's skin during surgery, and Aeroplast Dressing, the plastic spray-on surgical bandage, are their aids to improved asepsis. Products are distributed in Canada through Fisher & Burpe, Ltd., the Stevens Companies, and J. F. Hartz Company, Ltd.

For hospital and surgical groups Mr. Geen is scheduling showings of two sound-colour motion pictures demonstrating clinical applications of these products. "A New Transparent Plastic Skin Drape" was produced by the department of surgery at Ohio State University and "The Use of Aeroplast Dressing in Surgical Wounds" was created by the department of surgery at the University of Chicago.

Mr. Geen's headquarters are 17 Wythenshawe Wood, Scarborough, Ont.

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Suppliers Tell Us —

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Tool Basket Makes Mop Bucket Complete Cleaning Unit

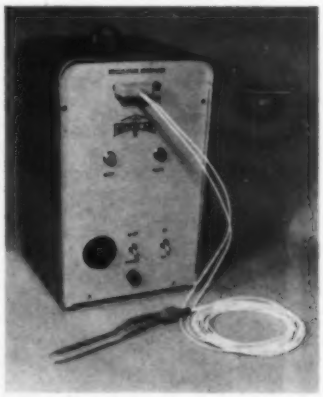
Designed to hold most tools and materials needed for cleaning operations, this new wire basket fits over the side of an 8- or 11-gallon mop bucket. Named "Task-Basket" by the makers, Geerpres Wringer, Inc., Muskegon, Mich., this accessory can be used to tote brushes, rags, bottles, et cetera, and eliminates an extra cart to carry supplies.

By stocking with spot-remover, extra rags, squeegee and similar equipment, time-consuming trips back to the supply closet can often be avoided.

The Task-Basket is made of heavy gauge wire and is chrome plated for corrosion resistance. Open mesh design allows full ventilation and quick selection of item desired. Task-Basket does not interfere with operation of mop wringers.

Electro-Coagulation Generator is Biotronics Product

Medtronic Inc. announces a new concept in Electro-Coagulation with the new cautery generator providing a full 100-watt output and specifically designed to power the Medtronic bipolar-unipolar cautery forcep. With this new team, only the bleeder is cauterized. Possibility of forceps burn to the surgeon or plate burn to the patient is eliminated. The unit changes to unipolar operation at the touch of a foot switch. For more information write the Canadian distributor, Canadian Biotronics Corporation Ltd., P.O. Box 744, Station B, Montreal 2, Quebec.



Hospital Workshop

(concluded from page 49)

meaning of various treatments and diagnostic procedures were raised. What is their effect on the patient's emotional reactions? It was agreed that clear and realistic information will improve confidence and the patient's relationship with the staff members carrying out the treatment.

It became evident that many questions required further discussion. The need for future seminars was stressed as an effective method of staff education. The study and clarification of problems in communication between staff and staff, staff and patients, staff and family, department and department, and hospital and community were encouraged for coming meetings. The good-feeling tone prevailing throughout the discussion testified to the gratifying communication that existed during the meeting.

Conclusion

In conclusion, the group as a whole indicated that they had spent a very enjoyable and profitable day. They showed that they were eagerly looking forward to another workshop and were already thinking in terms of carrying this program back to their departments. Apart from the importance of the subject matter was the fact that the workshop enabled the department heads and their assistants to be together away from the detail of the day-to-day operation of the hospital and to develop and strengthen their own relationships. This, in itself, could not help but accrue to the benefit of the whole hospital operation and thus, to the patient. The success of the program was actually beyond that which had been anticipated. ■

A father returned home from work as usual, to find his small son sitting on the front steps and looking mighty unhappy.

"What's wrong, son?" he asked.

"Just between you and me," the lad replied, "confidentially, I simply can't get along with your wife."

OUR ADVERTISERS

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PROFESSIONAL DIRECTORY